Washington State Tribal Medicaid Administrative Match (MAM)

Cost Allocation Plan (CAP)

January 23, 2008

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I. PREFACE

The Tribal Medicaid Administrative Match (MAM) Cost Allocation Plan (CAP) for Washington State is described in this document. It is designed to be used by Washington's federally recognized tribes when implementing the MAM program. Non-federally recognized tribes are not eligible to participate in MAM. This plan has been developed by the Department of Social and Health Services (DSHS) Health and Recovery Services Administration's (HRSA), Division of Program Support, Medicaid Administrative Match (MAM) Section in consultation with Tribes. Many of the procedures and practices described in this document are directed by the United State's Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

The purpose of the Tribal MAM program is to:

- Form a partnership between HRSA and participating federally recognized tribes;
- Share in the responsibility for promoting access to Medicaid health care for American Indians/Alaskan Natives (AIs/ANs); and to
- Reimburse tribes for administrative activities allowed by MAM.

It is the goal of HRSA to actively pursue and promote tribal MAM opportunities statewide. This program is intended to assist in the building and coordination of existing tribal community resources that serve tribal members, non-tribal members, and children and families.

Tribes interested in participating in the MAM program should contact the Medicaid Administrative Match Section at HRSA. Email your interest to either of these two contacts:

TODD SLETTVET
Tribal Medicaid Administrative Match Program Manager
sletttd@dshs.wa.gov

ALAN HIMSL
Medicaid Administrative Match Section Manager
himslaj@dshs.wa.gov

II. GOVERNMENT-TO-GOVERNMENT RELATIONS

A. FEDERAL GOVERNMENT AND INDIAN NATIONS

The United States Constitution recognizes Indian sovereignty by classing Indian treaties among the "supreme law of the land," and establishes Indian affairs as a unique area of federal concern. Early U.S. Supreme Court cases held that since the United States chose to relegate tribes to a dependent status in terms of tribal dealings with other nations, the federal government, then, also assumed a "Trust" responsibility toward the tribes and their members, commonly known as a "Federal Trust Responsibility". This trust responsibility requires that medical services be provided to federally recognized Indian Tribes, and that the federal government, not the state, has that responsibility.

In keeping with the obligation to carry out the federal trust responsibility in accordance with the government-to-government relationship set forth under federal Indian law, CMS policy requires it to consult with Indian Tribes around all issues that may impact the tribe *(See **Appendix A**: American Indian and Alaska Native Beneficiaries, Consultation, CMS's Consultation Strategy).*

B. WASHINGTON STATE AND INDIAN NATIONS

In 1989, the governor signed the Centennial Accord between the federally recognized Indian tribes of Washington State and the state of Washington *(See **Appendix B**: Centennial Accord)* in order to recognize and formalize the government-to-government relationship between the state and federally recognized tribes. In November of 1999, the New Millennium Agreement was signed by Washington State tribal leaders and state officials reaffirming and strengthening the Centennial Accord *(See **Appendix C**: Millennium Agreement).* By setting more specific goals for mutual commitment and establishing agency-level implementation guidelines for the Centennial Accord, the Millennium Agreement was intended to facilitate a more-efficient government-to-government relationship, and establish policy and protocols for working together collaboratively to improve services to both Indian and non-Indian people. DSHS policy 7.01 ***(Appendix D)*** was formulated after the signing of the Centennial Accord and clearly describes DSHS's commitment to consultation with federally recognized tribes of Washington State, recognized American Indian organizations, and individual American Indians and Alaska Natives in the planning of DSHS service programs, in order to ensure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington State.

This plan was developed in cooperation and consultation with Washington State Tribes and CMS. The intent of this plan is to address CMS concerns regarding the Tribal MAM program, and to ensure the program is in compliance with federal guidelines. In 2004, HRSA created a Medicaid Administrative Match section to respond to CMS concerns regarding the implementation of MAM programs in Washington State. As of the end of 2005, HRSA contracts with thirteen of the twenty-nine federally recognized tribes in the state of Washington. The first Tribal MAM contract was signed and executed in 1998.

III. INTRODUCTION TO TRIBAL MAM

A. WHAT IS MEDICAID?

Under Title XIX of the Social Security Act, the federal government and states share the cost of funding the Medicaid program, which provides medical assistance to certain low-income individuals. Federal Financial Participation (FFP) is the federal government's share for the state's Medicaid program expenditures. States may claim FFP for providing administrative activities that are found to be necessary by the Secretary of the U.S. Department of Health and Human Services for the proper and efficient administration of the state Medicaid Plan.

Summary: Title XIX is part of the Social Security Act related to Medicaid.

- It is a federal/state partnership to provide medical coverage for low-income children and families.
- In Washington, it is more commonly known as the Washington State Medicaid Plan.

B. MEDICAID ADMINISTRATIVE MATCH (MAM)

MAM is a federal reimbursement program for costs of "administrative activities" that directly support efforts to identify, and/or enroll children/individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. The overarching policy for MAM is that allowable administrative costs must be directly related to a state Medicaid plan or waiver service and be "found necessary for the proper and efficient administration of the state Medicaid plan."

Examples of reimbursable administrative activities include:

- *Medicaid outreach;*
- *Facilitating Medicaid eligibility determinations;*
- *Medicaid related case management and referral;*
- *Medicaid related program planning and policy development;*
- *Medicaid related training; and*
- *General administrative activities.*

The MAM program is administered through the State of Washington, Department of Social and Health Services (DSHS), Health and Recovery Services Administration (HRSA).

The goals of the MAM program are to:

- Assist children and families in accessing needed Medicaid services;
- Increase the number of children and adults receiving preventive care;
- Administer an effective, efficient statewide Medicaid Administrative Match program that supports the state Medicaid plan; and
- Increase the availability of providers to treat Medicaid eligible clients in Washington communities;

Other examples of MAM activities include:

- *Discussing access to health care with a parent/family;*

- *Assisting in early identification of children who could benefit from health services provided by Medicaid;*
- *Contacting pregnant and parenting teens about the availability of Medicaid prenatal and well baby care programs and services such as First Steps maternity support services; and*
- *Providing referral assistance to families where Medicaid services can be provided.*

In 2003, CMS developed the "Medicaid School-Based Administrative Claiming Guide". This guide is the only guide that has been developed by CMS, and, in general, is applicable to all MAM programs.

NOTE: CMS has instructed HRSA, that to a considerable extent, *"Tribal and Local Health Jurisdictions"* may be substituted for *"School District"* in the Guide since the general principles described apply to all MAM activities. Where the Guide describes MAM issues specific to *"Schools"* (e.g., IEPs), those issues should be ignored for the purposes of describing Tribal MAM. This Plan will describe issues specific to Tribal MAM. The Guide can be found on the HRSA Administrative Match Web page at
http://fortress.wa.gov/dshs/maa/mam/tribal/tribal_home.html

In summary, the CMS Guide:

- Provides a framework for states to use when implementing MAM programs;
- Provides guidelines for preparation of appropriate claims for MAM;
- Ensures reimbursement/payment is for appropriate activities which support effective and efficient administration of the state Medicaid plan;
- Promotes flexibility for program development and implementation;
- Ensures consistency with application of MAM requirements across regions and states;
- Assists with implementation of operational and oversight functions; and
- Provides technical assistance.

C. MAM PROGRAM PRINCIPLES

- Activities must be found necessary for the proper and efficient administration of the state Medicaid plan.
- Time study methodology must capture 100% of time for participating staff for the period being measured.
- Parallel coding for Medicaid and non-Medicaid activities is required to clearly identify those activities directly related to Medicaid.
- There is monitoring to avoid duplicate payments.
- Coordination of activities is expected and encouraged between tribes, other governmental entities, state Medicaid agency, providers, community non-profits and other agencies related to activities performed.
- There must be clear delineation between direct services and administrative activities.
- There must be allocable share of costs *(proportional share of costs based on the Medicaid Eligibility Rate)* and non-discounted activities. Outreach and facilitating eligibility/determination are not discounted; they are reimbursed as 100% Medicaid share at 50% FFP.
- The federal government and the states share the costs of providing MAM-allowable administrative activities.

- Enhanced rate of reimbursement for Skilled Professional Medical Personnel (SPMP) must follow CMS SPMP Guide. (SPMP claiming is not allowed under this Tribal MAM Cost Allocation Plan (CAP).
- Provider participation - referrals must be to a Medicaid provider.
- CMS reviews and approves programs and codes as meeting regulatory requirements ***(Tribal MAM CAP)***.
- Free care principle precludes Medicaid from paying for the costs of Medicaid coverable services and activities that are available to all in the general population without charge.

D. TRIBAL MAM

The Tribal MAM program was created to address a number of concerns. These include improving the relatively low rate of AI/AN enrollment in Medicaid and assisting AI/AN enrollees in accessing Medicaid services, thereby helping to address Indian health disparities by linking American Indian and Alaskan Native people with Medicaid in the face of compelling health needs and inadequate Indian Health Service (IHS) funding. (See **Appendix L** for Health Disparity Information).

By contracting for MAM, federally recognized tribes as well as eligible tribal organizations can be reimbursed for the costs of performing Medicaid administrative activities. This Plan will describe the CMS approved time-study methodology that tribes and eligible tribal organizations must use to document their Medicaid reimbursable administrative costs. Many tribes and tribal organizations are already providing these activities but are not being reimbursed for them. HRSA, in concert with the federal government and the tribes, has created a strategy by which tribes and tribal organizations can claim administrative costs, not otherwise reimbursed, for providing services that are directly related to the state Medicaid plan.

Tribes and eligible tribal organizations are in a unique position to participate in this program. Due to federal IHS policy, tribes must provide information about the Medicaid program, and assist those enrolled in Medicaid in gaining access to services and benefits. Through MAM, the related administrative costs can be reimbursed at a 50% match rate.

E. WHO QUALIFIES TO DO TRIBAL MAM?

Any federally recognized Indian Tribe in the state of Washington that wishes to participate in MAM is eligible. HRSA will conduct a site visit with interested tribes and eligible tribal organizations; provide necessary training, consultation, and on-going technical assistance; and will contract with those tribes and eligible tribal organizations that wish to participate in the MAM program.

F. WHERE DOES TRIBAL MAM TAKE PLACE?

MAM activities may take place anywhere Medicaid eligible tribal members, non-tribal members, families and/or children and contracted tribal personnel may interact. This could be in an office, clinic, and/or center, or during a home visit, as well as by telephone and at a meeting. The only allowable MAM activities that may occur in a home setting include outreach, facilitating Medicaid eligibility determinations or referral activities.

Tribes may offer a variety of programs other than those located in a clinic in which staff may perform activities eligible for MAM claiming. The most likely circumstances where MAM

claiming would be allowed would be when tribal staff assist Medicaid eligible individuals in enrolling in Medicaid *(eligibility determinations)*; or in referring individuals already enrolled in the Medicaid program to other Medicaid services. Any tribal "outreach-related" service with the goal of informing individuals about the Medicaid program and getting them to apply for Medicaid would also qualify as a MAM reimbursable activity.

A tribal program participating in MAM does not have to be a Medicaid provider in order to claim FFP if the program is providing Medicaid-related outreach or application/determination services and/or refers clients to Medicaid-covered services.

Tribal programs that may be able to claim MAM for outreach, assistance with eligibility determinations, and for referral to Medicaid-covered services include but are not limited to:

1. Tribal TANF
2. Elder/Senior services programs
3. Childcare programs
4. First Steps maternity support services *(pregnancy outreach, education, and nutrition services)*
5. Food assistance programs
6. Diabetes programs
7. Indian Child Welfare
8. Indian Health Service "Contract Health Services" program
9. Social services

G. NON-CLAIMABLE ACTIVITIES

Activities that are considered integral to or an extension of the specified Medicaid covered service could be termed "provider-extender" activities. Such activities are included in the rate set for the direct service, and therefore they should not be claimed as a Medicaid administrative expense.

MAM claiming is also not allowable for Medicaid-related case management services that are billable as Medicaid Targeted Case Management.

IV. PRINCIPLES OF ADMINISTRATIVE CLAIMING

A. GENERAL INFORMATION

Tribal employees may perform administrative activities that support the Medicaid program. Some or all of the costs of these administrative activities may be reimbursable under Medicaid; however, an appropriate claiming mechanism must be used. The time study is the primary mechanism for identifying and categorizing Medicaid administrative activities performed by tribal employees. The time study also serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under Medicaid.

The time study, including the activity codes, should represent the actual duties and responsibilities of participating tribal employees, consistent with the operational principles discussed below. Tribal MAM activity codes must be used to allocate administrative costs for purposes of making claims under the Medicaid program.

B. OPERATIONAL PRINCIPLES OF ACTIVITY CODES

1. Proper and Efficient Administration

In order for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be those that are "found necessary by the Secretary for the proper and efficient administration of the plan" *(referring to the Medicaid state plan).*

2. Capture 100 Percent of Time

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, an allocation methodology, or time study, must be used. The time study must incorporate a comprehensive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time study must reflect all of the time and activities *(whether allowable or unallowable for Medicaid administrative claiming)* performed by employees participating in the MAM program. The time study mechanism must entail careful documentation of all work performed by certain tribal staff over a set period of time and is used to identify, measure and allocate the tribal staff time that is attributable to Medicaid reimbursable activities. The unique responsibilities and functions performed by the time study participants, as well as the special factors and programs applicable to tribes, are accounted for and included in the time study codes. As these codes are formulated, they should be compared against the staff classifications and supporting position descriptions to ensure that all functions being performed are identified and incorporated into the codes.

3. Parallel Coding Structure: Medicaid and Non-Medicaid Codes for Each Activity

The time study activity codes must capture all of the activities performed by the time study participants, and distinguish Medicaid activities from similar activities that are not Medicaid reimbursable. The codes must also distinguish between those services that are covered under the Medicaid program and other medical or health care services that are provided by Tribal health programs but are not covered by Medicaid (eg. diabetes support groups, adult flu shots, etc). These distinctions can be accomplished through the use of "parallel" time study activity codes. For example, the time study would include an activity code such as

"Medicaid referral and coordination" and a parallel code such as "non-Medicaid referral and coordination". Using a parallel coding structure ensures that the time study captures 100 percent of the time spent on referrals and allocates it to the appropriate program. All staff in the sample universe should be trained on proper coding procedures, including reporting activities under the parallel codes, before sampling begins.

4. Assure No Duplicate Payments

Federal, state and local governmental resources should be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under Medicaid, duplicate payments are not allowable. That is, tribes may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source.

Examples of activities for which the costs may not be claimable as Medicaid administration due to the potential for duplicate payments:

- *Activities that are integral parts or extensions of direct medical services (including patient follow-up, patient assessment, patient education, or counseling). In addition, the cost of any related consultations between medical professionals that may occur is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost;*
- *Activities that have been, or could be, paid for as a Medicaid-covered service;*
- *Activities that have been, or will be, paid for as a service not covered by Medicaid;*
- *Activities that have been, or will be, paid for as a Medicaid administrative cost other than by claiming MAM reimbursement;*
- *Activities that are included as part of a managed care rate and are reimbursed by the managed care organization; and*
- *Costs for activities that are included in the IHS Encounter Rate.*

5. Coordination of Activities

In addition to avoiding duplicate payments, as discussed above in Principle 4, duplicate performance of activities should also be avoided. Under Principle 1, allowable administrative activities must be necessary "for the proper and efficient administration of the [Medicaid] State Plan," as well as for the operation of all governmental programs. Therefore, it is important in the design of tribal claiming programs that the tribe does not perform activities that are already being provided or should be provided by other entities, or through other programs.

6. Direct Services vs. Administrative Activities

The time study and activity codes must capture and clearly distinguish direct services from administrative activities. Typically, direct services have specific funding sources, claiming mechanisms, and documentation requirements related to the particular program or type of activity, and therefore should not be claimed as an administrative expense. Because the time study must capture 100 percent of the time *(see Principle 2, above)* spent by tribal employees, activity codes are designed to reflect all administrative activities and direct services that may be performed, only some of which are reimbursable under Medicaid. The

time study methodology should identify the costs of medical and other direct services and ensure that those costs are not included in the claims for Medicaid administrative activities. The activity codes used in the time study must distinguish among different types of activities and direct services, as well as whether or not they are Medicaid-related activities. Activities that are considered integral to, or an extension of, a Medicaid-covered service are included in the rate set for the direct service, and therefore they should not be claimed as a Medicaid administrative expense.

While some Medicaid-related case management activities may fall within the scope of both administrative and Targeted Case Management (TCM), a tribe may not claim costs for the same activities, both as targeted case management and administrative case management, per the duplicate payment provision discussed above.

TCM services are included in state Medicaid programs as an optional service, and are pre-approved by CMS. TCM enables states to target case management services to specific classes of individuals and/or to individuals residing in specified areas. Case management services are referred to as TCM services when the services are not furnished in accordance with requirements pertaining to state wideness or comparability. An example of a TCM service in Washington State is the First Steps Infant Case Management program. If an individual is receiving any TCM service through another provider, extra care must be taken by the tribe to ensure that there is no duplication of services, or duplicate claim for payment. All TCM related client services, if provided by the tribe, must be reported under Activity Code 4, Direct Medical Services.

7. Allocable Share of Costs

Since many tribal-based medical activities are provided both to Medicaid and non-Medicaid eligible individuals, the costs applicable to these activities must be allocated to both groups. This allocation of costs involves the determination and application of the proportional share of Medicaid individuals to the total number of individuals. Development of the proportional Medicaid share, which will be referred to as the Medicaid Eligibility Rate (MER) in this Plan, should relate to and be based on the claiming unit *(the entity submitting the claim)*. The proportional Medicaid share is then applied to the total costs of a specific activity for which the tribe is submitting claims for FFP, thereby discounting a portion of the costs. This process is necessary to ensure that only the costs related to Medicaid eligible individuals are claimed to Medicaid. *Note that not all activities are subject to the MER; activities such as outreach and facilitating Medicaid eligibility determinations are not discounted.*

Through the use of time studies that contain specific activity codes, the costs of tribal personnel are distributed to certain activities *(identified by time study codes)* to determine the administrative costs allocable to the Medicaid program. The universe of activity codes used in the time study as a group must capture the following categories of costs:

- U **U**nallowable: the activity is unallowable as administration under the Medicaid program;
- TM **T**otal **M**edicaid: the activity is solely attributable to the Medicaid program and as such is not subject to the application of the Medicaid share percentage *(this is sometimes referred to as "not discounted")*;
- PM **P**roportional **M**edicaid Share: the activity is allowable as administration under the Medicaid program, but the allocable share of costs must be determined by applying

the percentage of the Medicaid eligible population that has been determined for each tribe carrying out the time study; or

R **R**eallocated Activities: the activities which are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

To establish the proportional Medicaid share, the number of Medicaid eligible individuals must be determined for each tribe that is submitting a claim. This number serves as the numerator in a fraction, with the denominator being the total number of individuals served. This fractional value is then applied to the total costs applicable to the Proportional Medicaid Share (PM) time codes to determine the costs applicable to Medicaid administrative activities. Note that the number of Medicaid eligible individuals and the total number of individuals served must be identified for the same time period. For example, the total number of individuals seen in August, compared with Medicaid enrollment in November, may not be used.

(MER = The number of unduplicated Medicaid-enrolled individuals provided with any services in that quarter, divided by the total number of unduplicated individuals provided with any services that quarter.).

EXAMPLE OF PROPORTIONATE MEDICAID SHARE

The following example establishes how the Medicaid Share of the costs related to the activity should be proportionately allocated to Medicaid. The amount of FFP is then determined based on the activity costs that are allocable to Medicaid.

Gross activity costs = $1,500
Number of unduplicated Medicaid-enrolled individuals served by Tribe = 1,000
Number of unduplicated individuals served by Tribe= 5,000
MER: Number of Medicaid-enrolled individuals served/total individuals served = 1,000/5,000 = 20 percent
Activity = (referral, coordination, and monitoring of Medicaid services)
(Proportional Medicaid / 50 Percent FFP)
Gross activity costs = $1,500
MER (20 percent)
$1,500 X 20% = $300
Gross MAM claimable amount = $300
FFP rate (50 %): $300 X 50% = $150
Net FFP claimable amount $150

EXAMPLE OF REALLOCATED COSTS

The following example establishes how the costs of reallocated activities are calculated. The reallocated costs are subject to the MER. The amount of FFP is then determined based on the activity costs that are allocable to Medicaid.

Grand Total activity costs = $100,000
MER = 23%
Percentage of paid activities that are to be reallocated = 25%
Percentage of paid activities solely attributable to Medicaid (TM) = 6%
Percentage of paid activities that are proportionately Medicaid (PM) = 19%

Percentage of paid activities that are not MAM-allowable = 50%
Percentage of reallocated activities allowable for claiming
= 25((6+19)/(6+19+50)) = 8.33*
Gross MAM claimable costs of reallocated activities = $100,000 X 8.33% = $8,333
Discounted for the MER: = $8,333 X 23% = $1,916.59
FFP Rate (50 %): = $1,916.59 X 50% = $958.30
Net FFP claimable amount: = $958.30

8. Enhanced FFP Rates

Title XIX provides that, for certain professional personnel, administrative activities not included in the services rate may be claimed either at the non-enhanced 50% rate, or at the 75% SPMP rate, according to policy. SPMP claiming at the enhanced rate is allowable only under strictly defined circumstances. (See the CMS SPMP Guide – "Title XIX Financial Management Review Guide #1: Skilled Professional Medical Personnel"). **CMS has determined that SPMP claiming is not allowable for school-based claiming, and has applied that determination also to Tribal health operations.**

9. Provider Participation in the Medicaid Program

Administrative activities performed in support of medical services that are not coverable or reimbursable under the Medicaid program would not be allowable as Medicaid administration. In order for the medical service to be reimbursable under the Medicaid state plan, the following requirements must be met:

- The medical service must be furnished to a Medicaid eligible individual.
- The medical service must be included in the state's Medicaid state plan.
- The medical service is not provided free-of-charge to non-Medicaid individuals.
- The provider must furnish services as a participating provider in the Medicaid program, and have a provider agreement and a Medicaid provider identification number; or be qualified in the State of Washington to provide Medicaid services; or must furnish such services as a provider for Medicaid enrollees of a Medicaid MCO.

Referral activities allowable for MAM claiming must be aimed at assisting the Medicaid-enrolled patient in making a referral to a willing Medicaid provider for a Medicaid-covered service. Allowable MAM referral activities provided by tribal health programs include the time spent in searching for a willing provider and may include time spent in unsuccessful contacts with providers.

10. No Free Care

The "no free care" principle precludes Medicaid from paying for the costs of Medicaid-coverable services and activities which are generally available to all individuals without charge, and for which no other sources for reimbursement are pursued. In order for Medicaid payment to be available for services, the provider must:

1) Establish a fee for each service that is available;
2) Collect third party insurance information from all those served *(Medicaid and non-Medicaid)*; and

3) Bill other responsible third party insurers.

Federal policy provides for exception to the "no free care" principle with regard to services provided through the Indian Health Service.

11. Federal and State Financial Participation

The federal government and the state share the costs of providing MAM-allowable administrative activities. Federal legislation provides for FFP payments to the state for part of the state's expenditures for administration of the approved state Plan. The balance is the responsibility of "state match."

According to 42CFR 433.51, public funds may be considered as the state's share in claiming FFP if they meet the following specified conditions:

(a) The public funds are appropriated directly to the state or local Medicaid agency, or transferred from other public agencies *(including federally recognized AI/AN tribes)* to the state, or certified by the contributing public agency as representing expenditures eligible for FFP; and
(b) The public funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

For purposes of Tribal MAM, tribes certify the expenditures that constitute the "state match" portion. By contracting for MAM, they are able to be reimbursed for the federal share of the costs of Medicaid administrative activities.

12. Time Study Staff Training

All tribal staff participating in MAM must complete the required time study. Staff must receive adequate training before participating in their first time study. Staff will be expected to receive a "refresher" training once every four quarters, with signed documentation as evidence of such training. Staff should be clear on how to complete the time study form; know how to report activities under the appropriate time study codes; understand the difference between Medicaid-covered and other activities; and know where to obtain technical assistance if there are questions. Professional staff must understand the distinctions between the performance of administrative activities and direct medical services. There must be a mechanism in place to assess how often training is necessary and to revise the training schedule, if appropriate. To ensure consistent application, all training documentation should be maintained and available for audit purposes. Documentation must show the content of the training provided to participating MAM staff and the frequency of training. The frequency of training should take into account staff turnover.

13. Monitoring Process

In order to ensure that the time study is statistically valid *(for example, at the 95 percent or higher confidence level for a five percent error level)*, HRSA will monitor the compliance of tribes with the requirements of the time study methodology and activity codes each quarter. Tribes will establish a rate of MAM activities each quarter, per participating staff, by completing a random time study period. HRSA/RDA (Research and Data Analysis) will monitor the claim each quarter by analysis of back-up documentation submitted with the A-

19 billing. *(See VI, B. Documentation; and IX, Performance Standards/Program Monitoring, for an in depth discussion).*

14. Offset of Revenues

A program may not claim any federal match for administrative activities if its total cost has already been paid by federal sources, since a government program may not be reimbursed in excess of its actual costs, i.e., make a profit. Certain revenues must offset allocated costs in order to assure there are no profits, no unallowable federal match, and no duplication of payment. These offsets reduce the total amount of costs in which the federal government will participate. To the extent that other funding sources have paid or would pay for the costs at issue, federal Medicaid funding is not available and the costs must be removed from total costs *(See OMB Circular A-87, Attachment A, Part C., Item 4.a.).* All applicable credits must be offset against claims for Medicaid funds. Applicable credits refer to those receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs.

The following include some of the revenue offset categories which must be applied in developing the net costs:

- All "non-authorized" federal funds.
- All state expenditures which have previously been matched by the federal government
- All state grants that are a pass-through of federal funds.

Note, however, that federal funding to Indian tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act is specifically allowable as match for federal funds under Section 106(j) of Title I of P.L.93-638. See also at 25 USC 450j-1 and at 25 USC 458aaa-11(d).

15. Timely Filing Requirements

Federal Guidelines require that a claim for FFP must be filed within a two-year period that begins on the first day of the calendar quarter immediately following the quarter in which the expenditure was made. The implementing regulations for timely filing are at *45 CFR Subpart A* and provide specific guidelines for determining when expenditure is said to have been made, so as to initiate the two-year filing period. Federal regulations at *45 CFR 95.13(d)* indicate that a state agency's expenditure for administration is considered to have been made in the quarter the payment was actually made by the state agency.

Further, *45 CFR 95.4* identifies a state agency as any agency of the state, including the state Medicaid agency, its fiscal agents, a state health agency, or any other state or local organization which incurs matchable expenses.

Example: A tribe incurs MAM-reimbursable expenditure in January 2002. The end of the calendar quarter in which the expenditure occurs would be March 31, 2002. In order to meet the two-year timely filing limit, the state Medicaid agency must file a claim with CMS within two years after the calendar quarter in which the expenditure occurred, or by March 31, 2004.

In determining the two-year filing limit, the state agency must give consideration to the expenditure reporting cycle. The expenditure is not considered "filed" until it is received by CMS on the CMS-64 Expenditure Report, which is required to be filed 30 days after the end of a reporting quarter. This reduces the apparent amount of time in which the claim can be considered timely filed.

In Washington State, WAC 388-05-0010 requires that all MAM contractors, including tribes, submit final MAM billings for reimbursement for a given quarter within twelve months of the last day of the quarter.

16. No Contingency Fees

Medicaid claims for the costs of administrative activities and direct medical services may not include fees for consultant or contracted services that are based on, or include, contingency fee arrangements. Thus, if payments to consultants by tribes are contingent upon payment by Medicaid, the consultant fees may not be used in determining the payment rate of tribal-based services and/or administration.

With regard to the use of the services of consultants, OMB Circular A-87 states in item 33.a, of Attachment B, "Selected Items of Costs," that:

> *Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the federal government.*

V. WASHINGTON STATE TRIBAL MAM CLAIMING METHODOLOGY

A. COMPREHENSIVE ACTIVITY CODES

The following activity codes will be used for Tribal MAM. Staff must document time spent on each of the following coded activities using the Time Study Time Form *(Appendix E)*:

FFP is provided at 50% of the amount determined to be the Medicaid share.

(U) Unallowable: the activity is not allowable as administration under the Medicaid program.

(TM) Total Medicaid Administration 100% Medicaid Share this administrative activity is wholly attributable to the Medicaid program and as such is not subject to the application of discounting by the proportional Medicaid share percentage.

(PM) Proportional Medicaid Share: the activity is allowable as administration under the Medicaid program, but the Medicaid share of costs must be determined by applying the Medicaid percentage of the service population that has been determined for the Tribe. This discounts the costs by the Medicaid Eligibility Rate or MER.

(R) Reallocated Activities: those activities which are reallocated across other codes based on the percentage of all other time spent on allowable/unallowable administrative activities. FFP is provided at 50% of the reallocated proportionate Medicaid share. A single calculation of reallocation is made for the entire quarterly claim, based on the total MAM-claimable costs of all Tribal staff who participated in that quarter's time study.

CODE 1.a.	Non-Medicaid Outreach - U
CODE 1.b.	Medicaid Outreach - TM
CODE 2.a.	Facilitating Application for Non-Medicaid Programs - U
CODE 2.b.	Facilitating Medicaid Eligibility Determination - TM
CODE 3	Activities not Related to Medicaid Covered or Direct Medical Services - U
CODE 4	Direct Medical and/or Medicaid Covered Services - U
CODE 5.a.	Arranging Transportation for Non-Medicaid Services - U
CODE 5.b.	Arranging Transportation in Support of Medicaid Covered Services - PM
CODE 6.a.	Non-Medicaid Translation - U
CODE 6.b.	Translation Related to Medicaid Covered Services - PM
CODE 7.a.	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medicaid Services - U
CODE 7.b.	Program Planning, Policy Development, and Interagency Coordination Related to Medicaid Covered Services -PM
CODE 8.a.	Non-Medicaid Related Training - U
CODE 8.b.	Training Related to Medicaid administrative activities and/or Access to Medicaid Covered Services- PM
CODE 9.a.	Referral, Coordination, and Monitoring of Non-Medicaid Covered Services - U
CODE 9.b.	Referral, Coordination, and Monitoring of Medicaid Covered Services - PM
CODE 10	General Administration – R

For all the activity codes and examples listed below, if an activity is provided as part of, or an extension of, a direct, medical and/or Medicaid-covered service, it may not be claimed as Medicaid administration. Any staff activity involved in directly providing medical and/or Medicaid covered services should be assigned to Code 4. Direct Medical and/or Medicaid Covered Services.

CODE 1.a. NON-MEDICAID OUTREACH - U

All tribal staff should use this code when performing activities that inform individuals about their eligibility for non-Medicaid medical, social, vocational and educational programs and how to access them; and/or describing the range of benefits covered under these programs and how to obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Informing families about non-Medicaid health and wellness programs and how to access these programs and services, such as exercise classes, cooking for diabetes management, flu shots, WIC, etc.
2. Informing families about activities that educate individuals about the benefits of healthy life-styles and practices.
3. Informing individuals and families about general health education programs or campaigns that address life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
4. Conducting outreach campaigns that encourage persons to access social, educational, legal or other non-medical services.
5. Outreach activities in support of medical programs that are funded only by state general revenue.
6. Developing outreach materials such as brochures or handbooks for these programs.
7. Distributing outreach materials regarding the benefits and availability of these programs.

CODE 1.b. MEDICAID OUTREACH – TM/50 Percent FFP

Tribal staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program. Such activities include bringing potential eligibles into the Medicaid system for the purpose of the eligibility process. The following are examples of activities that are considered Medicaid outreach:

1. Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid *(including preventive treatment, screening and* services provided through the EPSDT program).
2. Developing and/or compiling materials to inform individuals about the Medicaid program *(including EPSDT)* and how and where to obtain those benefits. *Note: This activity should not be used when Medicaid-related materials are already available to the tribes (such as through the Medicaid agency). As appropriate, outreach materials developed by tribes should have prior approval of the Medicaid agency.*
3. Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
4. Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals and their families about health resources available through the Medicaid program.

5. Providing information about Medicaid EPSDT screening *(e.g., dental, vision)* in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
6. Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.
7. Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
8. Encouraging families to access medical/dental/mental health/chemical dependency services provided by the Medicaid program.
9. Assisting in early identification and enrollment of children with special medical/dental/mental health needs into Medicaid programs.

CODE 2.a. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS – U

This code should be used by tribal staff when informing an individual or family about programs not covered by Medicaid, such as Food Stamps, Women, Infants, and Children (WIC), day care, legal aid, and other social or educational programs, as well as health and wellness programs not covered by Medicaid, such as flu shots and exercise programs, and referring them to the appropriate agency to make application.

1. Explaining the eligibility process for non-Medicaid programs, including health and wellness programs not covered by Medicaid.
2. Assisting the individual or family collect/gather information and documents for a non-Medicaid program application.
3. Assisting the individual or family in completing the application, including necessary translation activities.
4. Developing and verifying initial and continuing eligibility for non-Medicaid programs.
5. Providing necessary forms and packaging all forms in preparation for the eligibility determination for a non-Medicaid program.

CODE 2.b. FACILITATING MEDICAID ELIGIBILITY DETERMINATION – TM/50 Percent FFP

Tribal staff should use this code when assisting an individual in the Medicaid eligibility process. Include related paperwork, clerical activities, or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility, which is not done by Tribal staff.

1. Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
2. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
3. Assisting individuals or families to complete a Medicaid eligibility application, including the Medicaid portion of a Tribal TANF application.
4. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability information, as a prelude to submitting a formal Medicaid application.
5. Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

6. Referring an individual or family to the local Community Service Office to make application for Medicaid benefits.
7. Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
8. Participating as a Medicaid eligibility outreach outstation *(but does not include determining eligibility, which is not done by Tribal staff).*

CODE 3. ACTIVITIES NOT RELATED TO MEDICAID-COVERED OR DIRECT MEDICAL SERVICES – U

This code should be used for activities paid by the tribe that are not medical or Medicaid-related, including non-Medicaid health and wellness activities, social services, educational services, teaching services, employment and job training These activities may include related paperwork, clerical activities, or staff travel required to perform these activities. Tribal services not related to Medicaid or to direct medical services can be reported in two ways: As a separate non-Medicaid code (Code 3) or as an example within one or more non-Medicaid activity codes.

CODE 4. DIRECT MEDICAL AND/OR MEDICAID-COVERED SERVICES - U

This code is used when providing direct care, medical/dental treatment, and/or clinical counseling services to an individual, included but not limited to:

1. Providing medical/dental/mental health/chemical dependency counseling treatment services.
2. Conducting medical/dental/mental health/chemical dependency assessments/evaluations and diagnostic testing and preparing related reports.
3. Providing personal aide services covered by Medicaid.
4. Providing speech, occupational, physical and other therapies.
5. Developing a treatment plan *(medical plan of care)* for a patient if provided as part of a medical or Medicaid-covered service
6. Providing immunizations.
7. Targeted Case Management *(if covered as a service under Medicaid).*
8. Transportation *(if covered as a service under Medicaid).*
9. Activities that are services, or components of services, listed in the state's Medicaid plan.
10. Participating in or providing training to enhance the knowledge and skills needed for provision of the above services.

CODE 5.a. ARRANGING TRANSPORTATION FOR NON-MEDICAID SERVICE – U

Tribal employees should use this code when assisting an individual in obtaining transportation to social, vocational, and/or educational programs and/or medical, health and wellness services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Arranging transportation to a diabetics' luncheon, sobriety camp, swimming program, gym, court hearing, GED class, office to make application for food stamps, etc.

CODE 5.b. ARRANGING TRANSPORTATION IN SUPPORT OF MEDICAID COVERED SERVICES – PM/50 Percent FFP

Tribal employees should use this code when assisting an individual in obtaining transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct costs of the transportation *(bus fare, taxi fare, etc.)*, but rather the administrative activities involved in arranging transportation. Include related paperwork, clerical activities or staff travel required to perform these activities. Note, if the Tribe has a contract with a Medicaid Transportation broker to receive reimbursement for providing transportation services, the tribal staff may not claim MAM when assisting patients in obtaining transportation covered under the contract. Instead, tribal staff must use Code 4. However, when tribal staff is arranging transportation for a non-tribal patient, or patient living off of the reservation, both of which are not covered under the Tribe's Medicaid transportation contract, Code 5.b. may be used.

CODE 6.a. NON-MEDICAID TRANSLATION - U

Tribal employees who provide translation services for non-Medicaid activities should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities. Non-Medicaid translation can be reported in two ways: As a separate non-Medicaid code (Code 6.a.) or as an example within one or more other non-Medicaid activity codes.

1. Arranging for or providing translation services *(oral or signing services)* that assist the individual to access and understand medical and healthcare services not covered by Medicaid, as well as for social, educational, and vocational services.
2. Developing translation materials that assist individuals to access and understand social, educational, and vocational and non-Medicaid medical and healthcare services.

CODE 6.b. TRANSLATION RELATED TO MEDICAID COVERED SERVICES – PM/50 percent FFP

Translation may be allowable as a Medicaid-claimable administrative activity, including translation in a direct service context, if it is not included and paid for as part of the medical assistance service. However, translation must be provided either by separate units or separate employees performing solely translation functions, and it must facilitate access to Medicaid covered services. Tribal employees who provide Medicaid translation services should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Arranging for or providing translation services *(oral and signing)* that assist the individual to access and understand necessary care or treatment covered by Medicaid.
2. Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 7.a. PROGRAM PLANNING, POLICY DEVELOPMENT, AND/OR INTERAGENCY COORDINATION RELATED TO NON-MEDICAID SERVICES - U

Tribal staff should use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-Medicaid services to patients/tribal members. Non-Medicaid services include social services, educational services, and vocational services, as

well as medical and other healthcare services that are not covered by Medicaid. Only employees whose position descriptions include program planning, policy development and interagency coordination may use this code. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying gaps or duplication of non-Medicaid services *(e.g., social, vocational educational and state mandated medical and general health care programs)* available to patients/tribal members, and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of non-Medicaid programs.
3. Developing procedures for tracking families' requests for assistance with non-Medicaid services and the providers of such services.
4. Evaluating the need for non-Medicaid services in relation to specific populations or geographic areas.
5. Analyzing non-Medicaid data related to a specific program, population, or geographic area.
6. Working with other agencies providing non-Medicaid services to improve the coordination and delivery of services and to improve collaboration around the early identification of problems not addressed by Medicaid-covered programs and services.
7. Defining the relationship of each agency's non-Medicaid services to one another.
8. Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-Medicaid services.
9. Developing non-Medicaid referral sources.
10. Coordinating with interagency committees to identify, promote and develop non-Medicaid services.

CODE 7.b. PROGRAM PLANNING, POLICY DEVELOPMENT, AND/OR INTERAGENCY COORDINATION RELATED TO MEDICAID-COVERED SERVICES – PM/50 percent FFP

This code should be used by tribal staff when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health/chemical dependency counseling services, and when performing collaborative activities with other agencies and/or providers to assure patients' access to Medicaid-covered services. It does not include activities integral to or an extension of direct medical or Medicaid-covered services, which would be coded under Code 4. Employees whose position descriptions include program planning, policy development and interagency coordination may use this code. Tribal managers need to be sure that "Participation in program planning and interagency coordination" is included in the job description of anyone who will be claiming any MAM time for this activity. This code refers to activities such as planning and developing procedures to track requests for services; while the actual tracking of requests for Medicaid services would be coded under Code 9.b., Referral, Coordination and Monitoring of Medicaid Covered Services. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying gaps or duplication of medical/dental/mental health/chemical dependency counseling services provided to patients/tribal members and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of medical/dental/mental health/chemical dependency counseling programs, including planning staff training to implement strategies.

3. Monitoring the medical/dental/mental health/chemical dependency counseling service delivery systems.
4. Developing procedures for tracking families' requests for assistance with accessing medical/dental/mental health/chemical dependency counseling services and providers, including Medicaid. *(This does not include the actual tracking of referral to Medicaid services, which would be coded under Code 9.b.)*
5. Evaluating the need for medical/dental/mental health/chemical dependency counseling services in relation to specific populations or geographic areas.
6. Analyzing Medicaid data related to a specific program, population, or geographic area.
7. Working with other agencies and/or providers that provide medical/dental/mental health/chemical dependency counseling services, to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to increase provider participation and improve provider relations.
8. Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental health/chemical dependency problems.
9. Developing strategies to assess or increase the cost effectiveness of medical/dental/mental health/chemical dependency counseling programs.
10. Defining the relationship of each agency's Medicaid services to one another.
11. Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop health services referral relationships.
12. Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services.
13. Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
14. Developing medical referral sources such as directories of Medicaid providers and managed care plans, which will provide services to targeted population groups.
15. Program planning and interagency coordination concerned with implementation of the Medicaid program, such as meetings with HRSA to develop guidelines for extending coverage of mental health services to family members of the Medicaid enrollee.

CODE 8.a. NON-MEDICAID RELATED TRAINING-U

Tribal staff should use this code when coordinating, conducting, or participating in training activities for outreach staff regarding the benefit of programs other than the Medicaid program. Include related paperwork, clerical activities, or staff travel required to perform these activities.

1. Participating in or coordinating training that improves the delivery of healthcare programs other than those covered by Medicaid.
2. Participating in or coordinating training that enhances IDEA child find programs, self-help sobriety programs, WIC, exercise workouts, healthy cooking, parenting classes, etc.
3. Continuing education.

CODE 8.b. TRAINING RELATED TO MEDICAID ADMINISTRATIVE ACTIVITIES AND/OR ACCESS TO MEDICAID-COVERED SERVICES-PM/50 Percent FFP

This code may be used when training activities benefit the Medicaid-eligible population. Tribal staff should use this code when coordinating, conducting, or participating in training activities designed to improve access to Medicaid covered services via enhanced referrals and assistance.

Include related paperwork, clerical activities, or staff travel required to perform these activities. Note, training that enhances the education/professional knowledge/skills needed in actually providing direct medical and/or Medicaid-covered services should be treated as Code 4, Direct Medical and/or Medicaid Services.

1. Participating in or coordinating training that improves access to Medicaid-covered services.
2. Participating in or coordinating training that enhances capacity for identification, intervention, screening and referral of individuals to Medicaid-covered services.
3. Participating in or coordinating training that improves Medicaid outreach.
4. Participating in or coordinating training for provision of assistance with Medicaid application and eligibility determination.
5. Training having to do specifically with Medicaid programs or eligibility (i.e. Healthy Options, First Steps), including administrative requirements related to Medicaid programs. *(e.g., Medicaid managed care, Targeted Case Management, EPSDT, etc).*

CODE 9.a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES – U

Tribal staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Making referrals for and coordinating access to medical and other healthcare services not covered by Medicaid (e.g. flu shots, exercise programs, WIC, childbirth and parenting classes, etc).
2. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
3. Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
4. Gathering any information that may be required in advance of these non-Medicaid related referrals.
5. Participating in a meeting/discussion to coordinate or review a patient/tribal member's need for services not covered by Medicaid.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of non-Medicaid Services. Case management may also be provided as an integral part of the service and in that case would be included in the service cost.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID COVERED SERVICES – PM/50 Percent FFP

This code should be used when making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services when the activity is not integral to or an extension of a Medicaid-covered service. This may include, but is not limited to the following activities. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Identifying and referring patients/tribal members who may be in need of Medicaid-covered family planning services.
2. Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health/chemical dependency evaluations, provided that such referral and/or coordination are not an extension of a direct service.
3. Screening patients' charts to identify any need for referral and/or follow-up services *(e.g., EPSDT screens, immunizations, PAP tests, mammograms, etc.).*
4. Referring patients/tribal members for necessary medical, dental, mental health, or substance abuse services covered by Medicaid.
5. Arranging for any Medicaid covered medical/dental/mental health/chemical dependency diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health/chemical dependency condition.
6. Gathering any information that may be required in advance of a medical/dental/mental health referral.
7. Participating in a meeting/discussion to coordinate or review a patient's/tribal member's needs for health-related services covered by Medicaid, provided that such participation is not an extension of a direct service.
8. Providing follow-up contact to ensure that a patient/tribal member has received the prescribed medical/dental/mental health/chemical dependency services covered by Medicaid.
9. Coordinating the delivery of medical/dental/mental health services for a patient/tribal member with special/severe health care needs.
10. Coordinating the completion of prescribed services, termination of services, and the referral of the patient/tribal member to other Medicaid service providers as may be required to provide continuity of care.
11. Providing information to other staff on the patient's/tribal member's medical/dental/mental health/chemical dependency services and plans, provided that such participation is not an extension of a direct service.
12. Coordinating medical/dental/mental health/chemical dependency service provision with managed care plans as appropriate.

Case Management: Note that case management as a Medicaid administrative activity involves the facilitation of access and coordination of only those services that are covered under the Medicaid program. Such activities may be provided under the term Administrative Case Management or may also be referred to as Referral, Coordination, and Monitoring of Medicaid Services. Depending on the setting and staffing, case management may also be provided as an integral part of a medical service and as such would be included in the service cost. The state may also cover targeted case management as an optional service under Medicaid. In that case, the activities are not claimable for MAM.

CODE 10. GENERAL ADMINISTRATION - R

This code should be used by time study participants when performing administrative activities that are not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel required to perform these general administrative activities. Note that tribal administrative staff expenses that are included in the Tribe's Indirect Costs Agreement (usually including accounting, payroll, executive direction, etc.), are only allowable through the application of the Tribe's approved indirect cost rate. Below are typical examples of general administrative activities, but they are not all inclusive.

1. Taking paid lunch, other paid breaks, paid vacation and sick leave, or other paid time not at work.
2. Reviewing tribal procedures and rules.
3. Attending or facilitating staff meetings, training, board meetings, or tribal council.
4. Performing administrative or clerical activities related to general tribal health department functions or operations, provided these are not included in the tribal indirect cost rate.
5. Providing general supervision of staff, including supervision and evaluation of employee performance.
6. Reviewing technical literature and research articles.
7. Attending interagency meetings and reviewing interagency correspondence.
8. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.
9. Performing managerial, administrative or clerical activities related specifically to implementation of the Tribe's MAM contract, including conducting the MAM time study, compilation of time study results, preparation of the billing statement, invoicing and coordinating with the state Medicaid agency with specific reference to Tribal MAM.
10. Participating in or coordinating training on the Tribal MAM program including code definitions; time sheet completion; and time study requirements.

B. CLAIMING

1. Documentation

Tribes must maintain records and be able to support the claims submitted to the state. The documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medicaid program. The administrative claiming records must be made available for review by state and federal staff upon request during normal working hours *(section 1902(a) (4) of the Act, implemented at 42 CFR 431.17)*. Documentation maintained in support of administrative claims must be sufficiently detailed to permit CMS to determine whether the activities are necessary for the proper and efficient administration of the state Medicaid plan. For most activities, the activity is self-evident in the detailed coding scheme. Additional guidance regarding documentation for compensation of salary and wages is found in OMB Circular A-87, Attachment B, Section 11.h. (5).

Personnel activity reports or equivalent documentation must meet the following standards:

- They must reflect an after-the-fact distribution (i.e., distribution following completion of the activity) of the actual activity of each employee;
- They must account for the total activity for which each employee is compensated;
- They must be prepared at least monthly and must coincide with one or more pay periods; and
- They must be signed by the employee as being a true statement of activities and the employee/office will retain documentation to support the report.

Note: the requirement to document costs at least monthly does not necessarily mean that time studies must be conducted monthly. OMB Circular A-87 makes a distinction between documentation of costs and the methods/mechanisms for allocating such costs. While costs must be documented at least on a monthly basis, time studies, which are conducted for purposes of allocating costs, can occur on a quarterly basis or some other statistically valid

time frame. In this CAP, Tribes will complete a one week per quarter time study. ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB Circular A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

The principles related to documentation and documentation requirements are:

- The documentation related to salaries and wages, including personnel activity reports, is required;
- Accounting records should be supported by source documentation such as canceled checks, paid bills, payrolls, contract and sub-grant award documents;
- The documentation related to foster care payments and administrative costs is required;
- Case management services based on time studies are an acceptable form of documentation for a given period;
- Costs must be verified as being incurred in a particular federal or other program;
- Undocumented personnel costs are not allowed; and
- Adequate documentation for labor costs is required.

C. TRIBAL MAM TIME STUDY

1. Tribal Time Study Methodology

a. Method

The following methodology is assures a randomized time period and a large enough sample of tribal staff statewide, to ensure that the time study is statistically valid at the 95 percent or higher confidence level for a 5 percent error level. HRSA, in consultation with Research and Data Analysis (RDA), will monitor the compliance of the tribes with the requirements of the time study methodology each quarter. (See IX for details of the monitoring process.)

- A time study shall be conducted for each contracting tribe for one week of every quarter. The tribe's week-long time study shall be randomly selected by HRSA and accepted as representative of Tribal MAM activities for that quarter.
- Every staff person, contracted staff, or sub-contractor claiming costs under this contract shall complete and sign a record of the actual activities engaged in by that person for all paid time throughout the work day during the period of the time study, by means of a detailed time study that breaks each hour of the working day into fifteen minute increments. The time study shall record all activities, and shall document not only Medicaid outreach and linkage activities, but also time spent in the provision of medical services, paid time off, and other non-reimbursable time, resulting in a complete picture of that person's activities.

- This signed documentation shall include, at minimum: 1) the name of the employee completing the time study and performing the allowable activities; 2) the employee's department or program and the employee's job title and/or

job description; 3) the dates covered by the time study; and 4) the activity code applicable to each fifteen minute increment of time during the work day.

- ***Appendix E*** displays the required time study form.

- ***Appendix F*** displays the required travel log to document costs claimed for MAM-related travel taking place that quarter.

- HRSA will ensure that tribes receive the necessary training annually.

b. Time Study Conditions/Exceptions

- Tribes may provide HRSA a yearly/quarterly calendar of weeks/days available for them to participate in the time study. If a tribe does not provide this schedule, all weeks/days will be treated as available for them to participate in the time study. HRSA will randomly select the week of the time study period each quarter. Tribes may exclude weeks/days as needed for holidays and special cultural events/activities with the permission of HRSA.
- Tribes will be allowed to request that HRSA randomly select a new time study period if the time study period occurs during an unanticipated event or may not be completed due to circumstances beyond the control of the tribe (i.e. illness of key staff, facility closure, elder's funeral, etc.).

D. CALCULATING THE MEDICAID ELIGIBILITY RATE (MER)

The Medicaid Eligibility Rate (MER) refers to the proportion of Medicaid enrollees in the patient population. This is determined separately for each contracting tribe. A participating tribe must verify and document each patient's/client's Medicaid eligibility and maintain that documentation for state and CMS review as requested.

An individual's Medicaid eligibility may be verified free of charge through the Washington State Medicaid (WAMED) web-address at:

https://wamedweb.acs-inc.com/wa/general/home.do

Each tribe will track both the unduplicated number of Medicaid-enrolled individuals provided with services during the quarter, and the total unduplicated number of individuals served during the quarter. Tribes shall determine these numbers each quarter and may use tribal databases and other resources, such as IHS RPMS (Resource & Patient Management System), ENVOY, etc.

Obtaining a copy of an individual's medical identification card and keeping it on file for review as requested is also an acceptable method.

The applicable MER must be calculated and documented for each quarter. Each Tribe must determine the MER for that quarter, calculated according to the following formula:

The total unduplicated number of Medicaid-enrolled individuals provided with services, divided by the total unduplicated number of individuals provided with services.

The Indian Nation Medicaid Eligibility Rate (MER) Worksheet and Certification Form (*see* ***Appendix G***) must be completed and signed by the tribe for each quarter, kept on file for state and federal review if requested, and a copy submitted to DSHS as an attachment with each A-19 Invoice Voucher quarterly billing and billing worksheet.

VI. BILLING AND PAYMENT PROCEDURES

A. FEDERAL FINANCIAL PARTICIPATION

1. Federal funds shall not be used as matching funds unless otherwise allowed by statute. The tribe shall ensure that its monetary share of costs for Medicaid administrative activities is non-federal monies, or eligible federal monies, or that they are tribal funds allowable as state match by regulation, and which has not been used and will not be used as match for other federal money.

2. In no case should a tribal health program or other tribal claiming unit be reimbursed more than the actual costs incurred by that program or claiming unit. In the event the tribe receives funds, other than funds received from Indian Health Services or under this Cost Allocation Plan, that are earmarked for outreach services for Medicaid, or for other administrative activities claimed under MAM, such funds shall be offset from the Medicaid administrative reimbursements.

B. ALLOWABLE COSTS

1. Personnel Costs

For purposes of Medicaid Administrative Match claiming, the tribe shall limit calculation of personnel costs to salary plus benefits, using payroll documents. The actual percentage of time spent that quarter on allowable reimbursable activities by each staff person is then multiplied by the personnel costs for that staff person to produce the claimable costs for that person's activities. Salary costs for the quarter must be readily determinable and based on data available from the tribal accounting office. These data shall tie to the quarterly payroll tax reports, providing a good audit trail for what is claimed as salary paid to the individual staff person for whom costs are claimed. In addition to salary, personnel costs shall include payroll taxes and fringe benefits. The cost of these benefits may be tied to the salary of an individual staff person, or a multiplier for benefits (that is, payroll taxes and fringe benefits as a percentage of salaries) may be calculated for staff of programs providing services under this Plan, based on accounting records. If used, the multiplier is entered to a cell on the billing spreadsheet that is referenced in the formula for each row, to produce a determination of the personnel costs (salary plus benefits) for each staff person. Personnel costs for contracted staff shall consist only of the compensation paid to or for that person, as documented by the tribal accounting office.

2. Travel Expenses

The tribe may claim allowable travel expenses that are incurred by staff in connection with their Medicaid administrative activities. Unlike personnel costs, which are allocated for the quarter based on data compiled from the week-long time study, travel expenses are claimed on a non-allocated basis. MAM-allowable travel expenses are limited to actual costs of travel that took place during the quarter, which were incurred in conducting specifically identified Medicaid administrative activities that are documented by the individual staff person on an ongoing quarterly travel log (see ***Appendix F***). Reimbursement for each individual travel event is calculated at the MER applicable to the specific activity. Reimbursement for travel is limited to per diem and mileage at prevailing federal rates plus documented transportation and hotel expenses. Travel expenses claimed for the quarter are

entered to the quarterly billing spreadsheet on a separate row for each staff person, with a breakout of travel expenses for TM (Total Medicaid) and PM (Proportional Medicaid).

3. Indirect Costs

Allowable personnel costs and travel costs constitute direct claimable costs. In addition, the tribe may claim indirect costs in accordance with OMB (the Federal Office of Management & Budget) Circular A-87. Indirect costs are calculated as the direct claimable costs for Medicaid administrative activities multiplied by the indirect rate negotiated by the tribe with the Inspector General, United States Department of Interior as documented by the applicable signed Indirect Cost Rate Agreement. A copy of the applicable negotiated Indirect Cost Rate Agreement must be available for review by state and federal inspectors.

The tribe must assure that costs claimed as direct costs (claimed through the time study process) do not duplicate costs claimed through the application of the indirect cost rate.

The federally-negotiated indirect rate (stated as a percentage) is to be applied to the sub-total amount claimed after direct cost calculations are complete. For tribes without an approved indirect rate, no indirect rate can be applied.

The approved indirect cost rate will be applied to each survey period of claiming within its applicable fiscal year. If the tribe does not have an approved indirect rate for the current fiscal year, the most recently approved indirect rate may be used.

C. PAYMENT FOR TRIBAL MAM CONTRACTS

1. Federal Financial Participation amount (FFP) for the Medicaid administrative activities which the tribe provides under this Plan is 50% of the total allowable costs that are attributable to Medicaid administrative activities.

2. The tribe shall ensure that its monetary share of costs for Medicaid administrative activities is non-federal monies, or eligible federal monies, or that they are tribal funds allowable as state match by regulation, and which has not been used and will not be used by the tribe as match for other Federal money. Accordingly, each A-19 Invoice Voucher (see ***Appendix H***) shall be signed by the tribe's representative and shall include the following statement:

   "Under the terms of the Contract between the parties, I certify that these expenses were incurred for allowable Medicaid MAM services provided to potential Medicaid participants or for Medicaid administrative purposes to Medicaid covered participants. I also certify that funds used to claim FFP are available, appropriate, and in accordance with the Code of Federal Regulations Title 42 section 433.51 (42 CFR 433.51)."

3. Payment for work under Tribal MAM contracts shall be subject to all the provisions of the contract and this Plan. The tribe may bill DSHS/HRSA for Medicaid administrative match activities performed during the contracted period of performance, provided there is adequate documentation of activities to substantiate the services claimed for reimbursement.

4. The tribe shall not submit billing, and DSHS/HRSA will not pay any amount in excess of the maximum compensation amount contracted. DSHS/HRSA will pay only for work performed

after the beginning date or before the expiration date of the contract, including properly executed amendments and extensions.

5. The tribe shall submit claims only for MAM allowable activities. Medicaid does not pay for administrative expenditures related to, or in support of, services that are not allowable for reimbursement by Medicaid and which are not included in the state Medicaid plan. In addition, Medicaid does not pay for health care services that are rendered free of charge to the general population, except for services rendered to Native Americans and to people of close social or economic ties to the Native American people, who are authorized under this contract or by the Indian Health Services to receive such services. Thus, any administrative activity, other than Medicaid outreach and application assistance, that supports the referral, coordination, planning, or other services that are provided free to the general non-tribal population, would not be considered as Medicaid administration.

6. The tribe shall strive to submit its claim for payment by the end of the second month following the end of the quarter. DSHS/HRSA shall reimburse the tribe within 30 days of receipt and approval of a properly executed A-19 Invoice Voucher. Final claims for payment submitted by the tribe to DSHS/HRSA for costs due and payable under tribal contracts that were incurred prior to the expiration date, including properly executed amendments and extensions, shall be paid by DSHS/HRSA if received by DSHS/HRSA within 90 days after the date of contract termination. Claims must be submitted in accordance with time limitations as outlined by federal guidelines.

7. The tribe shall determine the amount of Medicaid Administrative Claimable Costs according to the formulas below:

   a. For costs that are specifically Medicaid focused (i.e., those attributable to Medicaid outreach and application assistance, plus those attributable to other Medicaid focused administrative activities):

      The actual time spent by each staff person on allowable MAM activities divided by total time spent by that person for all paid activities [i.e., this yields a percentage amount of paid time] multiplied by that person's allowable wages and fringe benefits or contract fees.

   b. For activities that are claimable for reimbursement as Medicaid administrative activities only insofar as they are provided to Medicaid participants; i.e., case management, referral assistance, and allowable system coordination activities, the costs shall be discounted by the Medicaid eligibility rate (MER). Thus, claimable costs are calculated as:

      The actual time spent by each staff person on allowable MAM activities divided by the total time spent by that person for all paid activities multiplied by that person's allowable wages and fringe benefits or contract fees multiplied by the percentage of Medicaid enrollees in the service population.

   c. The billing worksheet (*see* ***Appendix I***) for calculating costs submitted to DSHS/HRSA must clearly demonstrate claimable costs that are allowable for FFP at 50%, as well as discounted and non-discounted rates, and a calculation of reallocated time. The Indian

Nation Medicaid Eligibility Rate (MER) Worksheet and Certification Form (***Appendix G***) must also be submitted along with the billing worksheet.

8. DSHS/HRSA shall reimburse the tribe on a quarterly basis for the total amount of FFP billed for allowable Medicaid administrative costs.

9. The tribe shall accept responsibility for any disallowances and/or penalties that CMS may determine during an audit, resulting from claims which DSHS/HRSA submitted on behalf of the tribe's billing of Medicaid. If the tribe bills and is paid administrative match money for services that are later found to be undelivered, ineligible for Medicaid administrative match, or not delivered in accordance with applicable standards, the tribe shall be responsible for any disallowances and/or penalties and shall fully cooperate in the recovery of funds.

10. The tribe shall provide DSHS/HRSA an itemized billing for MAM activities using the A-19 Invoice Voucher. Invoices shall include the following information: Name of tribe, contract number, period of performance, and total FFP claimed. Documentation in the form of the billing worksheet used to calculate the total invoice amount must accompany the invoice, together with the MER certification form.

11. The tribe shall bill DSHS/HRSA quarterly, for the total allowable reimbursement attributable to Medicaid administrative activities.

VII. PERFORMANCE STANDARDS/PROGRAM MONITORING

A. TRAINING

Each contracting tribe will designate at least one staff member to receive training from HRSA prior to the first quarter of the first time study of the new contract period. This staff person will be responsible for training all tribal staff claiming MAM. The HRSA Tribal MAM Program Manager will provide technical assistance/training to tribal MAM designated staff as requested/available, and conduct at least one technical assistance/monitoring visit at each contracted tribe each fiscal year.

HRSA will provide the required training materials in a variety of formats.

B. CONTRACT MONITORING PLAN

1. Scope of the Monitoring Plan

   This monitoring plan covers all current tribal contracts for MAM reimbursement for Medicaid-related activities including, but not limited to outreach, referral and eligibility determinations.

2. Monitoring Coordinator

   The Health and Recovery Services Administration (HRSA) Tribal MAM Program Manager, is currently responsible for monitoring contracts.

3. Risk Factors

   Tribes have multiple funding sources. As a governmental agency, they are covered under the Single Audit Act. Thus, the risk factor of multiple funding sources is reduced. Audit requirements under the Single Audit Act serve as an auxiliary monitoring tool.

   Tribes are audited frequently across multiple federal funding streams, and consequently, tend to have a great deal of practice and experience in maintaining good fund and grant accounting systems and audit trails. Because of long experience with federal and state grants and contracts, they are also familiar with and experienced in the need for compliance with contract requirements

   Staff turnover and complex multiple duties per staff person may be the most likely cause for contract non-compliance and billing errors. Tribes new to the MAM program may be more likely to make errors in claiming, due to the program's complexity. The required training, as well as the monitoring program and annual schedule of monitoring activities is designed to avert errors and identify those that occur, as well as require a corrective action plan in the event of their occurrence.

4. Monitoring Activities and Schedule

   The following monitoring activities will be conducted for all tribes receiving MAM reimbursement:

- Review of A-19 Invoice Vouchers and billing worksheets submitted for payment.
- Problem-solve issues/complaints regarding the administrative match policies and claiming.
- Respond to e-mail, fax, and phone contacts from contractors with questions;
- On-site monitoring and technical assistance will be provided at minimum once a year.
- During the yearly monitoring visit, and as tribes submit A-19 Invoice Vouchers and billing worksheets for MAM reimbursement, contract performance standards and MAM policies will be reviewed, and claims will be checked for accuracy, compliance and to ensure no duplication of claimed time. Training needs will be continuously evaluated.

5. Corrective Action

   The tribe will receive a yearly monitoring visit. A copy of the monitoring tool, including any identified corrective action items, will be provided to the Tribe no later than one month after the visit. The corrective action items will include contractor requirements and deadlines to address all findings.

6. Documentation and Reporting

   HRSA will maintain copies of the yearly monitoring tool in the contractor file, including all corrective action items. Documentation of technical assistance visits, training, and billing reviews will be maintained by HRSA.

VIII. Appendices (A-L)

Appendix A

American Indian and Alaska Native Beneficiaries Consultation

CMS's Consultation Strategy

This Centers for Medicare & Medicaid Services (CMS) policy on consultation with AI/AN Governments responds to the 1998 Executive Order on *Government-to-Government Relations with Native American Tribal Governments*, directives from the White House Domestic Policy Council Working Group on Indian Affairs, and recommendations from the Departmental Working Group on Consultations with American Indians and Alaska Natives. The guiding principle of the policy is to ensure that, pursuant to the special relationship between the United States Government and the Tribal Governments and to the greatest extent practicable and permitted by law, broad based input is sought by CMS prior to taking actions that have the potential to affect federally recognized tribes.

CMS acknowledges and accepts the following definition of consultation as developed by the HHS Working Group.

"Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in an effective collaboration and informed decision making."

CMS's consultation process will address all policies, regulations, and statutes applicable to the Medicare, Medicaid, and State Children's Health Insurance programs, including but not limited to eligibility, coverage, reimbursement, certification, and quality standards issues. With respect to the Medicaid program, CMS will require State participation in certain critical program change situations; such as, implementation of State-wide health care reform waivers and other waiver programs which clearly affect Indian people. CMS will strongly encourage the inclusion of Tribal groups in the development of other State health program proposals. All consultation processes will be mindful of the Government-to-Government relationship which exists between the Tribes and CMS.

A. **Goals of the Consultation Strategy**
   CMS has two primary goals for its consultation process:
   1. Establishing and Maintaining Communications
      CMS shall establish improved communication channels with Tribal officials and other AI/AN organizations as appropriate to increase knowledge and understanding of the Medicare, Medicaid, and State Children's Health Insurance programs. CMS will, in turn, learn from Tribal governments and organizations of the needs and concerns of their members, providers and health care partners serving the AI/AN population. CMS shall consult with Tribes about communication methods.
      A variety of methods and mechanisms will be necessary to effect communication with the more than 500 federally recognized tribes; for example, use of the Internet and other information technology may be necessary and appropriate in many situations. In some

cases, face-to-face or other two-way communication will be needed, for example, the introduction of major legislative change in our programs.

2. Establishing and Maintaining Ongoing Consultation Mechanisms
   As CMS enhances its communication channels with the Tribes, consultation will occur promptly and effectively and as an acknowledged part of daily business. CMS will share information with the Tribes and seek their input into proposed changes in the operation of the Medicare and Medicaid programs that have the potential to impact the lives of AI/AN individuals. Any proposed program changes will be communicated to the Tribes as early in the process as is practicable and appropriate.
   Inherent in the ongoing consultation processes within CMS is the need for technical assistance to Tribes in realizing the full potential of the Medicare, Medicaid, and State Children's Health Insurance program benefits for AI/AN beneficiaries and for providers of health services. In addition, CMS will strive to resolve problems and issues in a focused manner which is, as always, mindful of the Government-to-Government relationship as well as legal, fiscal and political constraints.

B. **Responsibility for Consultation**
   Responsibility for ensuring the consultation strategy is implemented, maintained, and continually improved and adapted to change, is vested in a joint partnership between CMS's headquarters and its regional offices. The Intergovernmental and Tribal Affairs Group (IGTAG), the Director of the Center for Medicaid and State Operations (CMSO), and the Regional Administrators with Seattle as the lead for all field activities, share joint responsibility for establishing effective communication mechanisms with Tribes and for ensuring effective ongoing consultation with Tribes.

C. **Implementation Steps**

1. Definition of Core Consultation Issues
   The Regional Office and CMSO, including IGTAG, with consultation from Tribes will develop a core group of issues and activities on which consultation will be sought or the criteria that will be used to identify such issues. Waivers and legislation affecting Tribes are considered critical for consultation.
2. Training of Staff
   CMS staff will participate in a training session on the Consultation Policy Statement and Agency expectations on a regular basis. The sessions may be by meeting, conference call, other broadcast or video format.
3. Ongoing Consultation with Tribes
   Where feasible, it is assumed that there is great value to both the Tribes and federal staff to conduct regular face-to-face meetings with the Tribes and/or to seek opportunities to participate in meetings conducted for the Tribes by others. These face-to-face meetings will provide additional and more issue-specific opportunities for CMS staff to seek and receive feedback from the Tribes on the consultation process, to provide technical assistance, and to assist in resolving problems and issues. Identification and resolution of issues will take place largely at the Regional level. Central Office personnel will be included in the consultation process and/or the Regional Office will provide information based on consultation in order to inform the policy making process.

D. **Additional Policies and Guidance in Consulting with Tribes**

1. A variety of mechanisms (e.g., Internet Web sites, meetings, telephones, newspapers, magazines and newsletters) will be explored and utilized to ensure timely and consistent exchange of information between the CMS Offices/Staff and the Tribes.

2. Consultation will occur directly between the CMS and the Tribes. While other interested organizations may also receive information and be asked for input, the primary mechanism for consultation by the CMS will be direct communication with the Tribes.
3. When consultation is sought from the Tribes, sufficient explanation of the issue and potential for impact on the Tribes will be provided by the CMS Office/Staff. All requests for input by the Tribes will state clearly what advice is requested and the time frame for response. As far as practicable, time frames will be of sufficient duration to allow communication by the Tribal Leaders with their constituency.
4. Tribes which provide advice or comments back to the CMS during a consultation process will be provided with timely feedback on the disposition of the issue for which consultation was requested. Time frames will be of sufficient duration to allow communication by the Tribal Leaders with their constituency.
5. CMS will ensure that states notify Tribes of proposed changes to state programs impacting Tribal members. CMS will also strongly encourage the inclusion of Tribal groups in the development of state proposals.
6. Although no government-to-government relationship exists between the CMS and urban Indian centers, significant numbers of AI/AN beneficiaries receive health services at these locations. Consultation with these centers is also encouraged whenever possible.

Summary: Consultation is viewed by the CMS as an evolving process. The joint partnership between the Center for Medicaid and State Operations (CMSO), Intergovernmental and Tribal Affairs Group (IGTAG), and the lead Regional Office will provide leadership for the implementation of the CMS Consultation Policy. Together the IGTAG and the lead Regional Office will ensure implementation of the Policy, make recommendations for revisions to the Policy based upon periodic assessments, and assure that issues surfaced by the Tribes are addressed promptly.

Attachment: List of Native American Contacts

Region & State	NAC	Phone, E-mail Address & Fax Number
Region X - Seattle **States: AK, ID, OR, WA**	Ernest Kimball DHHS/CMS 2201 Sixth Avenue, Rm. 911 Seattle, WA 98121-2500	(206) 615-2428 Ekimball@cms.hhs.gov (206) 615-2363 (fax)

Appendix B

Centennial Accord between the Federally Recognized Indian Tribes in Washington State and the State of Washington

I. Preamble and Guiding Principles

This Accord dated August 4, 1989, is executed between the federally recognized Indian tribes of Washington signatory to this Accord and the State of Washington, through its governor, in order to better achieve mutual goals through an improved relationship between their sovereign governments. This Accord provides a framework for that government-to-government relationship and implementation procedures to assure execution of that relationship.

Each Party to this Accord respects the sovereignty of the other. The respective sovereignty of the state and each federally recognized tribe provide paramount authority for that party to exist and to govern. The parties share in their relationship particular respect for the values and culture represented by tribal governments. Further, the parties share a desire for a complete Accord between the State of Washington and the federally recognized tribes in Washington reflecting a full government-to- government relationship and will work with all elements of state and tribal governments to achieve such an accord.

II. Parties

There are twenty-six federally recognized Indian tribes in the state of Washington. Each sovereign tribe has an independent relationship with each other and the state. This Accord provides the framework for that relationship between the state of Washington, through its governor, and the signatory tribes.

The parties recognize that the state of Washington is governed in part by independent state officials. Therefore, although, this Accord has been initiated by the signatory tribes and the governor, it welcomes the participation of, inclusion in and execution by chief representatives of all elements of state government so that the government-to-government relationship described herein is completely and broadly implemented between the state and the tribes.

III. Purposes and Objectives

This Accord illustrates the commitment by the parties to implementation of the government-to-government relationship, a relationship reaffirmed as state policy by gubernatorial proclamation January 3, 1989. This relationship respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues.

This Accord is intended to build confidence among the parties in the government-to-government relationship by outlining the process for implementing the policy. Not only is this process intended to implement the relationship, but also it is intended to institutionalize it within the organizations represented by the parties. The parties will continue to strive for complete institutionalization of the government-to-government relationship by seeking an accord among all the tribes and all elements of state government.

This Accord also commits the parties to the initial tasks that will translate the government-to-government relationship into more-efficient, improved and beneficial services to Indian and non-Indian people. This Accord encourages and provides the foundation and framework for specific agreements among the parties outlining specific tasks to address or resolve specific issues.

The parties recognize that implementation of this Accord will require a comprehensive educational effort to promote understanding of the government-to-government relationship within their own governmental organizations and with the public.

IV. Implementation Process and Responsibilities

While this Accord addresses the relationship between the parties, its ultimate purpose is to improve the services delivered to people by the parties. Immediately and periodically, the parties shall establish goals for improved services and identify the obstacles to the achievement of those goals. At an annual meeting, the parties will develop joint strategies and specific agreements to outline tasks, overcome obstacles and achieve specific goals.

The parties recognize that a key principle of their relationship is a requirement that individuals working to resolve issues of mutual concern are accountable to act in a manner consistent with this Accord.

The state of Washington is organized into a variety of large but separate departments under its governor, other independently elected officials and a variety of boards and commissions. Each tribe, on the other hand, is a unique government organization with different management and decision-making structures.

The chief of staff of the governor of the state of Washington is accountable to the governor for implementation of this Accord. State agency directors are accountable to the governor through the chief of staff for the related activities of their agencies. Each director will initiate a procedure within his/her agency by which the government-to-government policy will be implemented. Among other things, these procedures will require persons responsible for dealing with issues of mutual concern to respect the government-to-government relationship within which the issue must be addressed. Each agency will establish a documented plan of accountability and may establish more detailed implementation procedures in subsequent agreements between tribes and the particular agency.

The parties recognize that their relationship will successfully address issues of mutual concern when communication is clear, direct and between persons responsible for addressing the concern. The parties recognize that in state government, accountability is best achieved when this responsibility rests solely within each state agency. Therefore, it is the objective of the state that each particular agency be directly accountable for implementation of the government-to-government relationship in dealing with issues of concern to the parties. Each agency will facilitate this objective by identifying individuals directly responsible for issues of mutual concern.

Each tribe also recognizes that a system of accountability within its organization is critical to successful implementation of the relationship. Therefore, tribal officials will direct their staff to communicate within the spirit of this Accord with the particular agency which, under the organization of state government, has the authority and responsibility to deal with the particular issue of concern to the tribe.

In order to accomplish these objectives, each tribe must ensure that its current tribal organization, decision-making process and relevant tribal personnel is known to each state agency with which the tribe is addressing an issue of mutual concern. Further, each tribe may establish a more detailed organizational structure, decision-making process, system of accountability, and other procedures for implementing the government-to-government relationship in subsequent agreements with various state agencies. Finally, each tribe will establish a documented system of accountability.

As a component of the system of accountability within state and tribal governments, the parties will review and evaluate at the annual meeting the implementation of the government-to- government relationship. A management report will be issued summarizing this evaluation and will include joint strategies and specific agreements to outline tasks, overcome obstacles, and achieve specific goals.

The chief of staff also will use his/her organizational discretion to help implement the government-to-government relationship. The office of Indian Affairs will assist the chief of staff in implementing the government-to-government relationship by providing state agency directors information with which to educate employees and constituent groups as defined in the accountability plan about the requirement of the government-to- government relationship. The Office of Indian Affairs shall also perform other duties as defined by the chief of staff.

V. Sovereignty and Disclaimers

Each of the parties respects the sovereignty of each other party. In executing this Accord, no party waives any rights, including treaty rights, immunities, including sovereign immunities, or jurisdiction. Neither does this Accord diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this Accord parties strengthen their collective ability to successfully resolve issues of mutual concern.

While the relationship described by this Accord provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, that party's executive office.

Signatory parties have executed this Accord on the date of August 4, 1989, and agreed to be duly bound by it commitments.

Appendix C

Millennium Agreement

The work of the 1999 Tribal and State Leaders' Summit will be the foundation upon which our children will build. A stronger foundation for tribal/state relations is needed to enable us to work together to preserve and protect our natural resources and to provide economic vitality, educational opportunities, social services and law enforcement that allow the governments to protect, serve and enhance their communities.

The undersigned leaders of American Indian Nations and the State of Washington, being united in Leavenworth, WA on November 1, 2 and 3, 1999 in the spirit of understanding and mutual respect of the 1989 Centennial Accord and the government-to-government relationship established in that Accord, and desiring to strengthen our relationships and our cooperation on issues of mutual concern, commit to the following:

- Strengthening our commitment to government-to-government relationships and working to increase the understanding of tribes' legal and political status as governments;

- Continuing cooperation in the future by developing enduring channels of communication and institutionalizing government-to-government processes that will promote timely and effective resolution of issues of mutual concern;

- Developing a consultation process, protocols and action plans that will move us forward on the Centennial Accord's promise that, "The parties will continue to strive for complete institutionalization of the government-to-government relationship by seeking an accord among all the tribes and all elements of state government."

- Enhancing communication and coordination through the Governor's commitment to strengthen his Office of Indian Affairs and the member tribes' commitment to strengthen the Association of Washington Tribes;

- Encouraging the Washington Legislature to establish a structure to address issues of mutual concern to the state and tribes;

- Educating the citizens of our state, particularly the youth who are our future leaders, about tribal history, culture, treaty rights, contemporary tribal and state government institutions and relations and the contribution of Indian Nations to the State of Washington to move us forward on the Centennial Accord's promise that, "The parties recognize that implementation of this Accord will require a comprehensive educational effort to promote understanding of the government-to-government relationship within their own governmental organizations and with the public.";

- Working in collaboration to engender mutual understanding and respect and to fight discrimination and racial prejudice; and,

- Striving to coordinate and cooperate as we seek to enhance economic and infrastructure opportunities, protect natural resources and provide the educational opportunities and social and community services that meet the needs of all our citizens.

We affirm these principles and resolve to move forward into the new millennium with positive and constructive tribal/state relations.

Appendix D

American Indian Policy

DSHS Administrative Policy 7.01

BACKGROUND:

The Department of Social and Health Services (DSHS) follows a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and service program activities. This is in compliance with the Washington State 1989 Centennial Accord and current federal Indian policy as outlined by Executive Order #13175 signed by President Clinton in November 2000, which promotes government-to-government relationships with American Indian Tribes.

PURPOSE:

This policy defines the Department□s commitment to consultation with Federally Recognized Tribes of Washington State, Recognized American Indian Organizations, and individual American Indians and Alaska Natives in the planning of DSHS service programs, to ensure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington State.

SCOPE:

This policy applies to all DSHS programs and employees. DSHS administrators and regional program managers who oversee contracted services are also responsible for implementing this policy in the planning and delivery of contracted services.

DEFINITIONS:

Consultation: Consultation requires an enhanced form of communication that emphasizes trust and respect. It requires a shared responsibility that allows an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension.

Contracted Services: DSHS contracts with a large number of contractors to provide client services, personal services and purchased services. These contractors include individual providers, public agencies, and private (profit or non-profit) organizations. Among them are counties that receive contracts or grants to provide DSHS customers with alcohol and substance abuse treatment services, and counties that provide mental health services through Regional Support Networks. Other contracted agencies also provide licensing services, group care services, and other social and health services.

Culturally Relevant: This describes a condition where services provided to clients are appropriate according to the client's cultural backgrounds.

Dispute Resolution: When issues cannot be resolved through consultation process alone, a dispute resolution process may be useful to resolve technical issues, policy choices, or to ensure that the parties□ values have been given fair hearing and due consideration.

Federally Recognized Tribes: These are self-governing American Indian and Alaskan Native governments that are recognized under applicable federal and common law. Because of their unique sovereign status, Federally Recognized Tribes have the inherent power to make and enforce laws on their lands, and to create governmental entities.

Government-to-Government: This describes the relationships and protocols among and between Federally Recognized Tribes, and the federal, state, and other governments.

Indian Policy Advisory Committee (IPAC): This DSHS advisory committee is comprised of representatives from Federally Recognized Tribes of Washington State and the Recognized American Indian Organizations. It guides the implementation of the Centennial Accord and the DSHS American Indian Policy. The Office of Indian Policy and Support Services along with the Department tribal liaisons, provide technical support to IPAC in its ongoing communications through meeting, planning, and consultation activities. According to Article XI of the IPAC by-laws, IPAC does not have the authority or power to infringe or jeopardize the sovereignty of any Federally Recognized Tribe or non-member Tribe.

Key Identified Positions: These are DSHS managers and employees in regional or headquarters offices whose emphasis of responsibility is working in conjunction or association with the American Indian and Alaska Native Tribes. Employees in these key identified positions are required to attend the Administrative Policy 7.01 Training.

Office of Indian Policy and Support Services (IPSS): This office reports to the Secretary of DSHS and is responsible for coordinating efforts with Federally Recognized Tribes of Washington State and the Recognized American Indian Organizations in order to address the collective service needs of individual American Indians and Alaska Natives in Washington State.

Recognized American Indian Organizations: These organizations, as recognized in accordance to IPAC by-laws, include the American Indian Community Center (AICC), NATIVE Project, Seattle Indian Health Board (SIHB), Small Tribes of Western Washington (STOWW), United Indians of All Tribes Foundation (UIATF), and South Puget Intertribal Planning Agency (SPIPA), a tribal consortium. These organizations exercise their rights as American Indians and citizens of the United States and residents of the State of Washington.

Tribal Sovereignty: Federally Recognized Tribes are recognized in federal law as possessing sovereignty over their members and their territory. Sovereignty means that tribes have the legislative, executive, and judicial power to make and enforce laws, and to establish courts and other forums for resolution of disputes.

POLICY:

A. **General Guidelines**

1. DSHS shall provide necessary and appropriate social and health services to people of Federally Recognized Tribes of Washington State (Tribes) and Recognized American Indian Organizations (Indian Organizations) and American Indian and Alaska Native individuals.

2. DSHS recognizes, honors, and supports consultation with Tribes on a government-to-government basis, and with Indian Organizations.

3. In making policy on Indian issues, the Department shall acknowledge and consider:

    a. The sovereignty of Federally Recognized Tribes.

    b. The unique social/legal status of Federally Recognized Tribes under the Supremacy Clause and Indian Commerce Clause of the United States Constitution, federal treaties, executive orders, Indian Citizens Act of 1924, Indian Child Welfare Act of 1978, the Centennial Accord, other relevant statutes, and federal and state court decisions.

    c. American Indian self-determination and self-governance without the termination of the unique status of Federally Recognized Tribes.

    d. Recognition of Federally Recognized tribal governments as political governing bodies of sovereign American Indian and Alaska Native tribes.

    e. Cooperation and coordination with the Governors Office of Indian Affairs.

    f. The opportunity for Federally Recognized Tribes involvement and consultation in, but not limited to: the Department plans, budgets, policies, program services (including those provided by contractors and grantees), operational procedures, federal waivers or exemptions to state plans, that affect American Indian people.

4. DSHS shall ensure that programs and services to Tribes, Indian Organizations, and individual American Indian and Alaska Native are culturally relevant and in compliance with this policy.

5. DSHS shall conduct periodic evaluations of the responsibilities listed above to identify progress and outstanding issues.

6. DSHS shall explore the opportunity to develop a data collection process, in consultation with Tribes and Indian Organizations, to show statewide and tribal specific patterns of service use and access.

7. This policy does not waive, alter, or diminish the sovereignty of Federally Recognized Tribal governments: nor does it affect federal or tribal protected rights for Individual American Indians or Alaska Natives, or any other rights under the Centennial Accord, Treaty, Executive Order, self-determination, self-governance, or other applicable Federal, Tribal or State laws.

8. DSHS shall recognize the rights of Federally Recognized Tribes to bring their issues and needs to the direct attention of the Governor under the Centennial Accord at any time.

9. This policy defines specific duties and responsibilities for DSHS employees. This policy also provides opportunities for Tribes and Indian Organizations to participate in part or in total at their discretion. This policy is in full force and effect

regardless of the degree of participation of any Tribe or Indian Organization. DSHS employees shall extend the full benefit of this policy even if a Tribe or Indian Organization decides not to participate.

10. Each Regional Administrator, Field Services Administrator, or Division Director shall develop and submit a biennial Policy 7.01 Implementation Plan to his or her Assistant Secretary by April 2nd of each even-numbered year before the beginning of the biennium, and submit the annual Progress Report by April 2nd of each odd-numbered year. Each Assistant Secretary shall submit the consolidated Implementation Plan for his or her administration to the Office of Indian Policy and Support Services (IPSS) by April 30th of each even-numbered year, and submit the administrations annual Progress Reports to IPSS by April 30th of each odd-numbered year. IPSS shall provide to the Cabinet an overview of each administration's Implementation Plan by June 30th of the same year.

11. The Policy 7.01 Implementation Plan and the annual Progress Report shall be developed in consultation and collaboration with the Tribes and Indian Organizations. A uniform matrix format shall be used for the purpose of performance measurements. See Attachment 1: Policy 7.01 Implementation Plan Reporting Guidelines.

12. DSHS managers with appointing authority shall include representatives from Tribes and Indian Organizations as part of employee interview panels for key identified positions.

B. **Communications**

1. The IPSS staff and regional managers shall maintain the information distribution list within their regions and provide information to the Tribes and Indian Organizations on a regular basis.

2. IPSS shall hold quarterly meetings with each Assistant Secretary to timely identify issues between DSHS and the Tribes and discuss strategies for addressing the issues.

3. The Assistant Secretaries shall update the Cabinet on tribal relations and the status of their Policy 7.01 Implementation Plans specific to each administration.

4. The IPSS staff shall hold quarterly meetings with all programs liaisons/program managers identified by each administration to discuss collaboration and integration within DSHS with respect to tribal services.

5. IPSS shall schedule two Assistant Secretaries to attend each Indian Policy Advisory Committee (IPAC) meeting and discuss the planning for specific areas of partnership with the Tribes and Indian Organizations.

C. **Consultation Process**

1. Administrations of DSHS may initiate a consultation process with Tribes and also seek advice from IPAC at the same time. A detailed process and information is provided on page 12. Attachment 2: DSHS Administrative Policy 7.01 Consultation Flowchart.
2. Representatives from DSHS and Tribal government shall identify the participants in the two-way consultation process and establish participation at the appropriate level. Participants shall disclose any limitations on their ability to make decisions on behalf of the agency prior to consultation meetings.

3. Participants shall provide a clear description of the nature of the issues. Related documents or statements describing the purpose and issues shall be provided in advance to all consultation participants. Any sensitive information or legal limitations on or requirements for disclosure of information should be identified in advance.

4. Participants shall have sufficient time to review documents and respond to requests for consultation. The amount of time can vary depending on the nature and complexity of the issues. If decisions require quick actions due to imposed deadlines, every effort shall be made to provide written notice in advance to allow for meaningful input and response.

5. Participants shall establish and adhere to a schedule for consultation. DSHS and tribal participants shall jointly determine the protocols, timing and number of meetings needed for consultation.

6. Participants shall recognize that each Tribe is unique culturally and administratively. It is important to acknowledge tribal customary law or religious rules regarding issues of confidentiality.

7. Participants shall consider use of workgroups or task forces to develop recommendations on actions on various technical, legal or policy issues.

8. Participants shall report the outcomes of the consultation to the Tribes, Indian Organizations, DSHS Secretary, and appropriate administrations. With the goal to reach consensus as the outcome of the consultation, DSHS and tribal participants shall actively participate in the consultation so that all views can be considered. Once the consultation is

completed and a policy decision is final, all recommended follow-up actions shall be communicated, implemented, and monitored. The issue and the solution shall be incorporated into the Policy 7.01 Implementation Plan including all related attachments for record purposes.

D. **Dispute Resolution Process**

1. In light of the sovereign government status of Tribes, when consultation alone has not been successful in resolving issues at the regional level, Tribes have the authority to raise the issues to the Assistant Secretary, Secretary, or the Governor.

2. Depending on the particular issues involved, DSHS shall select the most appropriate dispute resolution mechanism from the following: mediation, agreed fact-finding, arbitration, or litigation within agreed parameters. Participation in this process does not waive, alter, or otherwise diminish the rights of either party to seek other actions or remedies provided for by applicable tribal, federal, or state law.

3. In a formal arbitration process, a hearing panel shall be established to perform the following duties:

    a. Notify the involved parties that a complaint has been filed.

    b. Determine if the case is eligible for a hearing under this policy.

    c. If the case is not eligible for a hearing, notify the involved parties that the case is not accepted and where the case shall be referred.

    d. If the case is eligible for a hearing, notify the involved parties when a case is accepted and when a hearing will be scheduled.

    e. Establish a time and place for a hearing, and notify the involved parties.

    f. Conduct a hearing and keep a record of the proceedings.

    g. Consider the facts presented by all involved parties and render a decision.

    h. Notify the involved parties of the decision.

4. Through the arbitration process, the involved parties use their collective ability to resolve issues of mutual concern. No party waives any rights including but not limited to treaty rights and immunities, including sovereign immunity or jurisdiction.

5. In cases where agreements cannot be reached, each party is free to pursue its interests through any means that it deems appropriate, including litigation. No party waives any rights including but not limited to treaty rights and immunities, including sovereign immunity or jurisdiction. In the event of litigation, agreements to meet and confer before litigation is filed may help to ensure each party understands the positions and interests of the other parties, and may provide opportunities to discuss how to reduce the time and cost of litigation for all concerned.

E. **Duties and Responsibilities**

1. The Secretary of DSHS shall: a. communicate with each Tribe, Indian Organization, and IPAC, review their recommendations, and where appropriate, implement the recommendations within the realm of his or her authority, and provide periodic updates to the Governor's Cabinet. b. Consider seeking legislative support for Tribal and Indian Organization programs and services when submitting budget request to the Office of Financial Management (OFM) and submitting legislative proposals related to social and health services. c. Support the federal model of self-determination and self-governance for tribal management of state funded programs while discussing relevant issues with OFM and the Governor's Office. d. Work with Tribes, Indian Organizations, and IPAC in assessing unmet needs, service gaps, and other outstanding issues, and address those issues within the realm of his/her authority. e. Consult with Tribes, Indian Organizations and IPAC before making substantive changes to IPSS or the American Indian Policy. f. Present the DSHS Policy 7.01 Progress Report each year to the: (1) IPAC members, Tribes and Indian Organizations, (2) the Governor□s Cabinet, and (3) DSHS Cabinet. 2. The Office of Indian Policy and Support Services (IPSS) shall: a. be responsible for the overall coordination, monitoring, and assessment of the department's relationships with Tribes and Indian Organizations. b. Facilitate DSHS communications and consultations on an ongoing basis with Tribes and Indian Organizations to ensure the department's thorough consideration of all suggestions and recommendations. c. Advocate for the delivery of DSHS services that are of high quality and culturally sensitive, and ensure that American Indian and Alaska Native children, families, and individuals can access DSHS services in a timely manner. d. Communicate with DSHS management, regional representatives and contractors to assist them in understanding and

implementing this policy. e. Monitor issues on services to American Indians and Alaska Native, bring issues to the appropriate administrator for resolution, and recommend specific actions to resolve issues in compliance with this policy. IPSS staff is authorized to participate at any level of DSHS, and to access any information necessary for the performance of their duties. f. Provide staff support to IPAC for its ongoing communications through meeting, planning, and consultation activities. g. Provide ongoing training and information on this policy to department and tribal staff. h. Work with administrators and Tribes of concern to resolve issues based on IPSS Director's reviews of Policy 7.01 Implementation Plans and progress reports with the Assistant Secretaries. 3. The Assistant Secretaries shall: a. Include consideration of resources (including State funds, contracts, or grants) to support Policy 7.01 planning activities, functions and goals when submitting budget requests to the Secretary for DSHS budget submittal to OFM. b. Include identified federal waivers or exemptions to their state plans when they are resubmitted, updated or modified to promote and enhance tribal self-determination and self-governance. Said waivers and exemptions shall have been identified in consultation with Tribes, Indian Organizations and IPAC. c. Review and utilize regional Policy 7.01 Implementation Plans to develop administration specific statewide plans. These plans shall capture common issues and potential problems and provide ways to bring attention to concerns specific to Tribes and Indian Organizations. d. In consultation with the Secretary, sponsor and participate in the annual statewide Policy 7.01 meeting where the activities of the Policy 7.01 Implementation Plans will be addressed and updated. e. Inform and seek input from IPSS when developing policies and procedures that will have a unique effect on Tribes or Indian Organizations. 4. Division Directors shall: a. Identify, measure and evaluate performance indicators of the division related to the implementation of this policy. b. Inform and seek input from IPSS when developing policies and procedures that will have a unique effect on Tribes or Indian Organizations. 5. Regional Administrators or Field Services Administrators shall: a. Seek tribal consultation in the development of biennial Policy 7.01 Implementation Plans, performance measures, and annual Progress Reports (see Attachment: Policy 7.01 Implementation Plan Reporting Guidelines). b. Inform and seek input from IPSS when developing policies and procedures that will have a unique effect on Tribes or Indian Organizations. c. Appoint Tribal Liaisons and provide opportunities for tribal specific training and participation in meetings and conferences as funding permits. Tribal Liaisons will attend IPAC meetings and along with IPSS staff provides technical support or information to the IPAC members. d. Identify, measure and evaluate performance indicators of the Region related to the implementation of this policy. ATTACHMENT 1 Policy 7.01 Implementation Plan Reporting Guidelines the Policy 7.01 Implementation Plans and the Annual Progress Reports shall be developed in consultation and collaboration with each Tribe and Indian Organization. A. Reporting Schedule: Each Regional Administrator or Field Services Administrator shall: 1. Develop and submit the biennial Policy 7.01 Implementation Plan to his or her Assistant Secretary by April 2nd of each even-numbered year for the following two fiscal years starting July 1. The purpose is to have a complete Implementation Plan ready to implement by July 1 of the next biennium. 2. Incorporate any amendments to the Policy 7.01 Implementation Plan as they are negotiated during the biennium, and immediately send the amendments to the Assistant Secretary. 3. Submit the first annual Progress Report to the Assistant Secretary by April 2nd of the next odd-numbered year. 4. Incorporate the second annual Progress Report into the next biennial Policy 7.01 Implementation Plan by April 2nd of the following even-numbered year, with the new goals, objectives or activities specifically noted. Each Assistant Secretary shall: 1. Submit the consolidated biennial plan for his or her administration to IPSS by April 30th of each even-numbered year. The purpose is to have a complete Implementation Plan ready to implement by July 1 of the next biennium. 2. Upon receiving any amendments to the Policy 7.01 Implementation Plan from the Regional Administrator or Field Services Administrator, review and finalize the amendments, and submit to IPSS within 30 days of approval. 3. Submit the administration's first annual Progress Report to IPSS by April 30th of the next odd-numbered year. 4. Incorporate the second annual Progress Report into the next biennial Policy 7.01 Implementation Plan by April 30th of the following even-numbered year, with the new goals, objectives or activities specifically noted. B. Planning Checklist This checklist is provided to assist the assigned employees in key identified positions in developing the Implementation Plan. This exercise can help identify areas that need to be improved upon. 0 1. Have you scheduled regular meetings with the Tribes to discuss Policy 7.01 Implementation Plan and/or Progress Report? When and how often do you meet? 0 2. Have your Administration, Region, Division, Program, Contractors or Grantees met with the Tribes in your area and identified issues that need to be addressed? What were the topics of the issues? What were the agreeable solutions? 0 3. Have you included Tribal contacts in your information sharing, problem-solving and planning activities? Who are your contacts at the Tribe? 0 4. Have you notified Tribes of funding opportunities, RFP□s, available grants, or training opportunities from DSHS? What were they? 0 5. Do you have any special/pilot projects that include tribal participation or need to have tribal participation? What are they? 0 6. Are your employees trained to address culturally sensitive issues or have access to culturally relevant resources? 0 7. Is your program/division able to respond to current needs of the tribes? How? 0 8. Did your program or division provide training to the Tribes? What tribes? What kind of training was provided? 0 9. Was technical assistance provided to the Tribes? If yes, in what capacity? 0 10. Do you have Local Area Agreements or current working agreements with the Tribes? What are they? Are they current? 0 11. Do you contract directly with the Tribes? What are these contracts? 0 12. Do you have a plan for recruiting Native American providers, contractors, or employees? 0 13. Did you inform and seek input from IPSS when developing policies and procedures that will have a unique effect on Tribes or Indian Organizations? 0 14. Do you have issues or concerns that require assistance from the Office of Indian Policy and Support Services (IPSS)? Have you discussed these issues with IPSS? C. Format The matrix below shall be used for both Implementation Plan and Progress Report starting no later than 2006. Policy 7.01 Implementation Plan Biennium Timeframe: July 1, ____ to June 30, ____ Plan Due Dates: April 2 (Regional Plan submitted to Assistant Secretary) and April 30 (Assistant Secretary Plan submitted to IPSS) of each even-numbered year. Progress Report Due Dates: April 2 (Regional Plan submitted to Assistant Secretary) and April 30 (Assistant Secretary Plan submitted to IPSS) of each odd-numbered year. Implementation Plan Progress Report (1) Goals/Objectives (2) Activities (3) Expected Outcome (4) Lead Staff and Target Date (5) Status Update for the Fiscal

Year Starting Last July 1 ATTACHMENT 2 DSHS Administrative Policy 7.01 Consultation Flowchart Administration in DSHS Identifies the issue that needs to be resolved through consultation and advisory processes. Consultation Process1 Sends a letter to each tribe and requests for consultation. Sends a letter to IPAC members and requests for advice. Advisory Process1 Tribes Indian Policy Advisory Committee (IPAC) Provide consultation comments to the administration2. Works with Tribal Leaders and provides their advisory comments to the administration2. Offers to form a joint DSHS/Tribal workgroup to review the comments and develop a model for the identified issue. Provide comments and/or appoint a delegate to participate in the workgroup process. Sends a letter and offers technical assistance to the administration and to the Tribes3. Decide whether to form a new workgroup or accept the offer of IPAC as the lead resource for the consultation on the identified issue5. Offers to use the IPAC□s subcommittee for the administration to lead the consultation on the identified issue. May use the IPAC's subcommittee for the administration as the forum for the workgroup process4. Reports the outcomes of the consultation to the Tribes, DSHS Secretary, IPAC, and other administrations that could be affected. Footnotes: 1 The consultation with Tribes can be occurring at the same time that IPAC is performing their advisory work. 2 Sometimes it may be the same employee who provides the consultation comments on behalf of the Tribe and also prepares the advisory comments as an IPAC delegate. 3 The IPAC letter would also include a list of the current IPAC delegates and subcommittee members. This would make it easier for Tribal Leaders to identify people who are already working on the issues through IPAC. 4 Many Tribes have already designated delegates to IPAC, and the existing subcommittee could be the lead resource for Tribes to work on the joint DSHS/Tribal model development. 5 Some Tribes may prefer to use their existing IPAC delegates and work through the IPAC subcommittee rather than having duplicate meetings on the same issue.

Exhibit E

Washington State Tribal Medicaid Administrative Match

TIMESTUDY CODES

1.a	Non-Medicaid Outreach
1.b	Medicaid Outreach
2.a	Facilitating Application for Non-Medicaid Programs
2.b	Facilitating Medicaid Eligibility Determination
3.	Activities Not Related to Medicaid-covered of Direct Medical Services
4.	Direct Medical and/or Medicaid-covered Services
5.a	Arranging Transportation for Non-Medicaid Services
5.b	Arranging Transportation in Support of Medicaid-covered Services
6.a	Non-Medicaid Translation
6.b	Translation Related to Medicaid-covered Services
7.a	Program Planning, Policy Development and/or Interagency Coordination Related to Non-Medicaid Services
7.b	Program Planning, Policy Development and/or Interagency Coordination Related to Medicaid-covered Services
8.a	Non-Medicaid Related Training
8.b	Training related to Medicaid Administrative Activities and/or Access to Medicaid-covered Services
9.a	Referral, Coordination, and Monitoring Non-Medicaid-covered Services
9.b	Referral, Coordination, and Monitoring of Medicaid-covered Services
10.	General Administration (to be reallocated)

Exhibit E

Tribe: ____________________ **Staffperson's Name:** ____________________________ **Program + Job Title:** ____ **MONTH:** _______________ **YEAR:** _____

Please complete the log below for each Time Study day assigned to you, by entering the appropriate code for EVERY block of time shown on the log.

See Time Study Codes on the back of this sheet.

For EACH 15-minute period of the day, choose the ONE code which best describes the activity you performed during that period.

Please write in INK, not pencil, and do not use correction fluid (WiteOut, etc). If you make a mistake, just cross it out and write in the space immediately below.

After completing your timestudy form/s please review it , sign and date it, and turn it in to your supervisor.

The spaces below are for Administative use only

Day / Date	8am - 9am				9am - 10am				10am - 11am				11am - noon				noon - 1pm				1pm - 2pm				2pm - 3pm				3pm - 4pm				4pm - 5pm				TM-PM	
	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	R	
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Day / Date	8am - 9am				9am - 10am				10am - 11am				11am - noon				noon - 1pm				1pm - 2pm				2pm - 3pm				3pm - 4pm				4pm - 5pm				TM-PM	
	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	R	
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Day / Date	8am - 9am				9am - 10am				10am - 11am				11am - noon				noon - 1pm				1pm - 2pm				2pm - 3pm				3pm - 4pm				4pm - 5pm				TM-PM	
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Day / Date	8am - 9am				9am - 10am				10am - 11am				11am - noon				noon - 1pm				1pm - 2pm				2pm - 3pm				3pm - 4pm				4pm - 5pm				TM-PM	
	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	R	
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I certify that this is a true and accurate record of my activities for the time reported above.

*Date:*______________ *Signature:*____

Total Medicaid (100%)	Proportional Medicaid	To be Reallocated	Total Paid Units

Space within all shaded areas is for Administrative use only

Exhibit E (blank)

ribe: ____________________ **Staffperson's Name:** ____________________________ **Program + Job Title:** ____ **MONTH:** _______________ **YEAR:** _____

Please complete the log below for each Time Study day assigned to you, by entering the appropriate code for EVERY block of time shown on the log.

See Time Study Codes on the back of this sheet.

For EACH 15-minute period of the day, choose the ONE code which best describes the activity you performed during that period.

Please write in INK, not pencil, and do not use correction fluid (WiteOut, etc). If you make a mistake, just cross it out and write in the space immediately below.

After completing your timestudy form/s please review it , sign and date it, and turn it in to your supervisor.

The spaces below are for Administative use only

Day / Date	TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TM-PM
	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	15	30	45	60	R
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Day / Date	TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TIME: -				TM-PM
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________																																					Total Paid

I certify that this is a true and accurate record of my activities for the time reported above.

Date: _____________ ***Signature:*** ____

Total Medicaid (100%)	Proportional Medicaid	To be Reallocated	Total Paid Units

Space within all shaded areas is for Administrative use only

Exhibit F

Washington State Tribal Medicaid Administrative Match

QUARTERLY TRAVEL LOG - Period: _____200__

This log is required for claiming expenses related to travel associated with MAM-claimable activities .
ONLY travel tor activities that would be MAM-claimable should be recorded.

NAME (print) _____ **Program / Department & Job Title** _____

						FOR ADMIN USE ONLY		
DAY and DATE	LOCATION / DESTINATION	MAM ACTIVITY CODE/S	BRIEF DESCRIPTION of ACTIVITY /ACTIVITIES (purpose of travel, mode/s of transportation, other kinds of expenses)	***Auto Mileage (Number of miles)***	***Mileage $$s***	***per diem $$s***	***Other Expenses $$s***

I certify that the above is a true and accurate report of my travel and related expenses .

TOTAL MCD expenses

PROP'TIONAL MCD expenses

pg ____ of ____ **Date:** _____ **Signature:** _____

Appendix G

Indian Nation Medicaid Eligibility Rate (MER) Worksheet and Certification Form

Tribe :

Contract # :

Quarter :

MER :

Provide Medicaid Eligibility Formula:

The total unduplicated number of Medicaid-enrolled individuals provided with services, divided by the total unduplicated number of individuals provided with services.

Insert Formula:

Supporting documentation of the MER must be kept on file for review/audit purposes as needed, including databases utilized.

I certify that the information provided above is true, and that documentation is available for review upon request.

Signature:_____ Date:_____

Appendix H

FORM **A19-1A** (REV. 6/95)

STATE OF WASHINGTON
INVOICE VOUCHER

AGENCY USE ONLY		
AGENCY NO.	LOCATION CODE	P.R. OR AUTH NO.
3000	9GF4	

AGENCY NAME

DSHS-Health and Recovery Services Administration
Division of Program Support
Medicaid Administrative Match Section
PO Box 45508
Olympia WA 98504-5508

VENDOR OR CLAIMANT

Agency Name
Agency Address

INSTRUCTIONS TO VENDOR OR CLAIMANT: Submit this form to claim payment for materials, merchandise or services. Show comlete detail for each item.

Vendor's certificate: I hereby certify under penalty of perjury that the items and totals listed herin are proper charges for materials, merchandise or services furnished to the State of Washington, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, or Vietnam era or disabled veterans Status

BY _____ (SIGN IN INK)

(TITLE) (DATE)

FEDERAL I.D. NO. OR SOCIAL SECURITY NO. (For Reporting Personal Services Contract Payments to I.R.S.)	RECEIVED BY	DATE RECEIVED

DATE	DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	AMOUNT	FOR AGENCY USE
	For services rendered in performance under					
	Contract #					
	for the period:					
	Match Rate:					
	50%					
	DSHS 3% Admin Fee				$0.00	
				Total	$0.00	

Under the terms of the Contract between the parties, I certify that these expenses were incurred for allowable Medicaid MAM services provided to potential Medicaid partricipants or for Medicaid administrative purposes to Medicaid covered participants. I also certify that funds used to claim FFP are available, appropriate, and in accordance with the Code of Federal Regulations Title 42 section 433.51 (42 CFR 433.51).

PEREPARED BY	TELEPHONE NUMBER	DATE	AGENCY APPROVAL	DATE

DOC. DATE	PMT DUE DATE	CURRENT DOC. NO.	REF. DOC. NO.	VENDOR NUMBER	USE TAX	UBI NUMBER
		VHZ				

ACCOUNT NUMBER 30 CHARS: Contract #

VENDOR MESSAGE 25 CHARS: Tribal Ad Match

TRANS CODE	FUND	MASTER INDEX: APPN INDEX	MASTER INDEX: PROGRAM INDEX	SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	MOS	PROJ	SUB PROJ	PROJ PHAS	AMOUNT	INVOICE DATE	INVOICE # 30 CHARS
	001		H9951	EZ	7330	H710	5156		8AM			$0.00		50%
			H9952			H760	0811					$0.00		3% Admin Fee

ACCOUNTING APPROVAL FOR PAYMENT	DATE	WARRANT TOTAL	WARRANT NUMBER
		$0.00	

Appendix I

TRIBAL MEDICAID ADMINISTRATIVE MATCH - BILLING WORKSHEET (Formulas for Calculations)

Tribe : ______________________________

Quarterly Period : ______________________________

Fringe benefits as a percentage of salary costs this quarter (overall rate) -	27%
"Total Medicaid" percentage of time -	100%
Medicaid eligibility rate (MER) this quarter -	24%
Tribe's negotiated Indirect Costs rate applicable to the claimed costs -	38%

Formulas for calculation of Percent of Time {T} and Amount of Costs {C} - (given with reference to Row 16 - the first row on the worksheet)

TM -	T = $N16/$L16	C = $V16*$S16*L6
PM -	T = $O16/$L16	C = $V16*$S16*L7

See below for re-allocation formulas pertaining to General Administration activities

SUMMARY of FFP CLAIMED

SubTotal - FFP at 50% Match for Direct Costs -	#DIV/0!
SubTotal - Tribal Indirect Costs at 50% FFP -	#DIV/0!
TOTAL FFP CLAIMED -	#DIV/0!

			Input Data for this Quarter									Calculations - Time		Calculations - Costs				FFP Claimed for Direct Costs
									Timestudy Results			Percentage of Total Paid Time				Amount of Claimable Costs		
ID Code	Staffperson's Name	Position / Job Description	Total Salary Costs for the quarter	Salary Costs to be Offset	Allowable Salary Costs to be shown on another worksheet	Allowable Salary Costs reported on this worksheet	Allowable Travel Expense	# of quarter-hrs of Paid Time in this weeklong timestudy period	Total Medicaid [# of qtr-hrs of Paid Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [# of qtr-hrs of Paid Time to be discounted by the MER]	General Administration [# of qtr-hrs of Paid Time - Direct Costs only - to be reallocated below]	Total Medicaid [% of qtr-hrs of Paid Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [% of qtr-hrs of Paid Time to be discounted by the MER]	Applicable Fringe Benefits Rate	Allowable Personnel Costs [Salary + Benefits or Contractual Compensation] this quarter	Total Medicaid [Costs of Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [Costs of Time after discounting by the MER]	Federal Financial Participation (FFP) at 50%
	HIDE																	
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
						$0.00						#DIV/0!	#DIV/0!	27.0%	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
												#DIV/0!	#DIV/0!	NA - contracted	$0.00	#DIV/0!	#DIV/0!	#DIV/0!
																$0.00	$0.00	$0.00
																$0.00	$0.00	$0.00
																$0.00	$0.00	$0.00
								0	0	0	0				$0.00	#DIV/0!	#DIV/0!	#DIV/0!

MAM re-allocated portion of General Administration (GA) Time = {a} as a percent of {b} =		#DIV/0!	#DIV/0!	- MAM-reallocated costs of General Administration (but not Indirect-Cost) activities
{a}	#DIV/0!	- GA as a percent of Total Paid Time (TPT)	#DIV/0!	- Proportionate Medicaid costs of reallocated General Administration activities
{b}	#DIV/0!	- MAM activities as a percent of all MAM-allowable and unallowable activities {TPT minus GA}		**FFP at 50% Match for Reallocated General Administration -** #DIV/0!

TRIBAL MEDICAID ADMINISTRATIVE MATCH - BILLING WORKSHEET (Example)

Tribe : _____

Quarterly Period : _____

SUMMARY of FFP CLAIMED

SubTotal - FFP at 50% Match for Direct Costs -	$8,553.32
SubTotal - Tribal Indirect Costs at 50% FFP -	$1,625.13
TOTAL FFP CLAIMED -	$10,178.45

Fringe benefits as a percentage of salary costs this quarter (overall rate) -	27%
"Total Medicaid" percentage of time -	100%
Medicaid eligibility rate (MER) this quarter -	24%
Tribe's negotiated Indirect Costs rate applicable to the claimed costs -	38%

Formulas for calculation of Percent of Time {T} and Amount of Costs {C} - (given with reference to Row 16 - the first row on the worksheet)

TM -	T = $N16/$L16	C = $V16*$R16*L6
PM -	T = $O16/$L16	C = $V16*$S16*L7

See below for re-allocation formulas pertaining to General Administration activities

			Input Data for this Quarter									Calculations - Time		Calculations - Costs				FFP Claimed for Direct Costs
								Timestudy Results				Percentage of Total Paid Time				Amount of Claimable Costs		
ID Code	Staffperson's Name	Position / Job Description	Total Salary Costs for the quarter	Salary Costs to be Offset	Allowable Salary Costs to be shown on another worksheet	Allowable Salary Costs reported on this worksheet	Allowable Travel Expense	# of quarter-hrs of Paid Time in this weeklong timestudy period	Total Medicaid [# of qtr-hrs of Paid Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [# of qtr-hrs of Paid Time to be discounted by the MER]	General Administration [# of qtr-hrs of Paid Time - Direct Costs only - to be reallocated below]	Total Medicaid [%of qtr-hrs of Paid Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [%of qtr-hrs of Paid Time to be discounted by the MER]	Applicable Fringe Benefits Rate	Allowable Personnel Costs [Salary + Benefits or Contractual Compensation] this quarter	Total Medicaid [Costs of Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [Costs of Time after discounting by the MER]	Federal Financial Participation (FFP) at 50%
	HIDE																	
PA	Patricia Abbott	Tribal Health Director	$15,000.00			$15,000.00		160	12	48	50	7.50%	30.00%	27.0%	$19,050.00	$1,428.75	$1,371.60	$1,400.18
JD	James Dean	Medical Director	$30,000.00			$30,000.00		128	6	42	20	4.69%	32.81%	27.0%	$38,100.00	$1,785.94	$3,000.38	$2,393.16
CS	Cheryl Smith	Health Administrator	$9,000.00			$9,000.00		160	15	8	30	9.38%	5.00%	27.0%	$11,430.00	$1,071.56	$137.16	$604.36
AS	Ann Sanders	Community Health Nurse	$10,000.00	$4,000.00	$2,000.00	$4,000.00		120	8	70	8	6.67%	58.33%	27.0%	$5,080.00	$338.67	$711.20	$524.93
MP	Monica Parsley	Benefits Specialist	$7,500.00			$7,500.00		160	30	30	6	18.75%	18.75%	27.0%	$9,525.00	$1,785.94	$428.63	$1,107.28
IS	Imogene Spot	Dental Clinic Manager	$9,000.00			$9,000.00		160	6	20	20	3.75%	12.50%	27.0%	$11,430.00	$428.63	$342.90	$385.76
CC	Caroline Carter	Patient Advocate	$6,000.00			$6,000.00		160	15	30	6	9.38%	18.75%	27.0%	$7,620.00	$714.38	$342.90	$528.64
CB	Carol Black	Comm Health RN (contracted)	$6,000.00			$6,000.00		80	0	60	4	0.00%	75.00%	NA - contracted	$6,000.00	$0.00	$1,080.00	$540.00
PA	Patricia Abbott	Tribal Health Director					$530.00		$230.00	$300.00						$230.00	$72.00	$151.00
JD	James Dean	Medical Director					$700.00			$700.00						$0.00	$168.00	$84.00
MP	Monica Parsley	Benefits Specialist					$320.00		$320.00							$320.00	$0.00	$160.00
								1,128	92	308	144				$108,235.00	$8,103.85	$7,654.76	$7,879.31

MAM re-allocated portion of General Administration (GA) Time = {a} as a percent of {b} =	5.19%	$5,616.76	- MAM-reallocated costs of General Administration (but not Indirect-Cost) activities	
{a} 12.77%	- GA as a percent of Total Paid Time (TPT)	$1,348.02	- Proportionate Medicaid costs of reallocated General Administration activities	
{b} 40.65%	- MAM activities as a percent of all MAM-allowable and unallowable activities {TPT minus GA}		FFP at 50% Match for Reallocated General Administration -	$674.01

TRIBAL MEDICAID ADMINISTRATIVE MATCH - BILLING WORKSHEET (Annotated)

Tribe : _____ *- Name of Tribe / Tribal Health Center / Tribal Health Authority*

Quarterly Period : _____ *- The billing claim must be calculated on a calendar-quarter basis*

Formulas for calculation of Percent of Time {T} and Amount of Costs {C} - (given with reference to Row 16 - the first row of timesheet data on the worksheet)

The formulas are shown so they can be checked in case of possible corruption

Fringe benefits as a percentage of salary costs this quarter (overall rate) -	**xx%**	*- To be recalculated each quarter if an overall rate is going to be used*	*Total Medicaid -* **TM -**	% of Time = *formula* Costs = *formula*
"Total Medicaid" percentage of time -	**100%**	*- "Total Medicaid" by definition is 100%*	*Proportional Medicaid -* **PM -**	% of Time = *formula* Costs = *formula*
Medicaid eligibility rate (MER) this quarter -	**xx%**	*- To be recalculated each quarter*	**See below for re-allocation formulas for General Administrative activities**	
Tribe's negotiated Indirect Costs rate applicable to the claimed costs -	**38%**	*- Most recent negotiated rate applicable*		

SUMMARY of FFP CLAIMED

FFP at 50% Match for Direct Costs - *C + D (below)*

Indirect at 50% - *A+B+{e} multiplied by the Indirect Rate times 50%*

TOTAL FFP CLAIMED - *sum of the two figures above*

							Input Data for this Quarter						Calculations - Time		Calculations - Costs				FFP Claimed for Direct Costs
	HIDE								Timestudy Results				Percentage of Total Paid Time				Amount of Claimable Costs		
A	ID Code	Staffperson's Name	Position / Job Description	Total Salary Costs for the quarter	Salary Costs to be Offset	Allowable Salary Costs to be shown on another worksheet	Allowable Salary Costs reported on this worksheet	Allowable Travel Expense	# of quarter-hrs of Paid Time in this weeklong timestudy period	Total Medicaid [# of qtr-hrs of Paid Time engaged in !00% Medicaid-focused activities]	Proportional Medicaid [# of qtr-hrs of Paid Time to be discounted by the MER]	General Administration [# of qtr-hrs of Paid Time - Direct Costs only - to be reallocated below]	Total Medicaid [% of qtr-hrs of Paid Time engaged in 100% Medicaid-focused activities]	Proportional Medicaid [% of qtr-hrs of Paid Time to be discounted by the MER]	Applicable Fringe Benefits Rate	Allowable Personnel Costs [Salary + Benefits or Contractual Compensation] this quarter	Total Medicaid [Costs of Time engaged in !00% Medicaid-focused activities]	Proportional Medicaid [Costs of activities after discounting by the MER]	Federal Financial Participation (FFP) at 50%
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19

Row " A" (above) shows the headings that actually appear on the billing worksheet. - Row "B" (below) is shown here only to provide an explanatory comment on the above headings.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
B	Coding the ID makes it possible for column 2 to be hidden	Staffperson's Name - the name is shown on the copy of the worksheet kept in the Tribe's audit file, but the column is hidden on the copy of the worksheet that is submitted to HRSA, to protect the person's identity	Staffperson's Position / Job Description - enables HRSA to have a sense of what are the tasks that are reflected in the coding, and assists in identifying the staffer if needed at some later time	To be supported by payroll information (such as quarterly payroll tax reports)	Costs paid by federal funding sources that are not allowable as match (eg. MCH, SDPI, etc)	Some allowable costs might be shown on a separate worksheet if they pertain to a different costcenter, to which a different fringe benefits rate, or Indirect Costs rate, or MER might apply	Column 4 minus columns 5 and 6	To be supported by travel records and receipts for MAM-related travel that took place during the timestudy week and matching to the timesheet - but only if the travel was paid by allowable funding sources reportable on this worksheet	Per timestudy (supported by the actual timesheet) - total number of units of paid time [TUPT]	Quarter-hour units of time per timestudy (supported by the actual timesheet) - "Total Medicaid" applies only to activities that are coded 1b and 2b	Quarter-hour units of time per timestudy (supported by the actual timesheet) - "PM" applies to activities that are coded 5b / 6b / 7b / 8b / 9b	Quarter-hour units of time per timestudy (supported by the actual timesheet) - "Reallocation" applies only to direct costs reported as General Administration activities (code 10)	Spreadsheet calculation - number of units of time in column 10 as a percentage of TUPT in column 8	Spreadsheet calculation - number of units of time in column 11 as a percentage of TUPT in column 8	Fringe benefits must be recalculated each quarter, as they vary over the course of the year; however, it would be tedious (if not impossible) to make the individual calculation for each staffperson; instead, an overall calculation can be made quarterly for all staff shown on the spreadsheet, with the spreadsheet picking up the overall rate entered above and showing it in this colurm; however, if individual calculations are preferable, it is possible to do that by writting in "not applicable" in the space above for the overall rate, and entering the individual percentages to this column; either way, the applicable percentage is then picked up in the next column - note, compensation for contracted personnel on this worksheet does not include a calculation for fringe; if applicable, it has already been included in their compensation	Total compensation - personnel costs for regular staff consist of salary plus fringe benefits (the fringe percentage must be derived from actual finge costs for the quarter, to be supported by GL data); compensation paid for contracted personnel does not include a calculation for fringe on this worksheet	Spreadsheet calculation - personnel costs from column 15 multiplied by the percentage of time from column 13 - with no discounting applicable to Total Medicaid activities	Spreadsheet calculation - personnel costs from column 15 multiplied by the percentage of time from column 14 multiplied by the MER rate above	Allowable FFP calculated as 50% of the sum of columns 16 and 17

		HIDE																	

The data that are shown below the column headings on the Example Worksheet are only for purposes of illustration. Note that the data for "Regular Staff", "Contractors", and "Travel" must be entered to separate sections of the worksheet, as they require different formulas.

The travel calculation takes the costs of MAM-related travel throughout the quarter as reported in column 8, and breaks that out according to whether the related activities were T-M (Total Medicaid) or P-M, putting the breakout into columns 10 and 11. Further on, in columns 16 and 17, those costs are multiplied by the applicable MER (100% or discounted), and then in column 18 by 50% FFP.

									SUM of UNITS of TIME in this column	*SUM of UNITS of TIME in this column*	*SUM of UNITS of TIME in this column*	*SUM of UNITS of TIME in this column*			*SUM of all COSTS in this column*	*[A] SUM of all COSTS in this column*	*[B] SUM of all COSTS in this column*	*[C] SUM of all COSTS in this column*

MAM re-allocation of General Administration (GA) - ***calculations based on the Totals shown on row above -***

{a} below expressed as a percentage of {b} below = {c}

Total personnel costs (col 15) multiplied by MAM-allowable percentage of reallocated GA Time {c} = {d}

- MAM Direct Costs of Reallocated General Administration

{a} - *GA time (col 12) expressed as a percentage of Total Paid Time (TPT) (col 8)*

{d} multiplied by the MER = {e}

- Proportionate Medicaid costs of Reallocated Administration

{b} - *Time spent on MAM allowable activities (cols 10+11) expressed as a percentage of total allowable and unallowable activities (col 9 minus col 12)*

FFP at 50% Match for Reallocated General Administration - *[D] = {e} times 50%*

Appendix J

Tribal Medicaid Administrative Match (MAM)
Contract Monitoring Tool

Tribe:

Contract start date:

Date of monitoring visit (One monitoring visit per fiscal year is the expectation):

HRSA Site Visit Staff:

Todd Slettvet
Program Manager
HRSA

Tribal MAM Staff Present:

I. Time Study/Training

Obligation	Met	Not Met*
Contract Reference: (**See Exhibit B, I.B. Staff Training);** "To ensure consistent application, all training documentation must be maintained and available for audit/monitoring purposes, as requested by HRSA or CMS staff." "The Tribe will select and designate a Tribal MAM Coordinator to be trained by HRSA staff prior to the first time study period."		
1. *A tribal MAM coordinator was identified by the tribe and was trained by HRSA prior to the first time study. (Obtain a copy of the training documentation for the monitoring file).*		
Comments:		
Contract Reference: (**See Exhibit B, I. B. Staff Training**); "The Tribe's MAM Coordinator is responsible to ensure Tribal staff is trained in the MAM activity codes and time study methodology, utilizing HRSA training materials, before participating in a time study, or before claiming MAM reimbursement."		

2. *There is documentation that each staff member participating in MAM received training prior to his/her first time study period. Documentation includes the name of the trainer, trainee, date and signature (Obtain a copy of the training documentation/materials used if different from HRSA training materials).*		
Comments:		
Contract Reference: (**See Exhibit B, I.B. Staff Training);** "The frequency of training should take into account staff turnover, and is recommended at least once every four quarters."		
3. *There is documentation that staff received "refresher" MAM training at least once every four billing quarters. (Obtain copy of training documentation for monitoring file)*		
Comments:		
Contract Reference :(See Exhibit B, I.A. Method); "Participating staff must document 100 percent of their paid time during the time study period. Time must be recorded in fifteen minute increments and must adhere to the principle of parallel coding, using the required time study form".		
4. *Each staff member participating in MAM completed the time study as directed by HRSA according to the contract terms (i.e. 15 minutes increments; 100% time for the full week (7 consecutive days) selected. (Obtain sample copies of staff time sheets for the monitoring file).*		
Comments:		

*Any Obligation not met automatically becomes an action item.

Action Items:

II. Tribal MAM Activity Codes

Obligation	**Met**	**Not Met***
Contract Reference: (**See Exhibit B, I. B. Staff Training**); "It is expected that Tribal staff will understand how to complete the time study form; know how to report activities under the appropriate time study code; understand the difference between health related and other activities; know the distinctions between the performance of administrative activities and providing direct medical services; and know where to obtain technical assistance if he or she has questions".		

1. The Tribal MAM coordinator demonstrates a reasonable understanding of all MAM activity codes based on interview questions (a copy of the interview form is attached).		
Comments:		
2. Selected tribal staff demonstrate a reasonable understanding of all MAM codes based on interview questions (a copy of each interview form is attached)		
Comments:		
Contract Reference :(See Exhibit B, I.A. Method); "Participating staff must document 100 percent of their paid time during the time study period. Time must be recorded in fifteen minute increments and **must adhere to the principle of parallel coding**, using the required time study form".		
3. Parallel coding was used by all participating staff during each one week (7 consecutive days) time study period. Obtain sample copies of staff time sheets.		
Comments:		

*Any Obligation not met automatically becomes an action item.

Action Items:

III. MER

Obligation	**Met**	**Not Met***
Contract Reference: **(See Exhibit B, III. C. Calculating and Applying the Medicaid Eligibility Rate (MER))**; "Documentation of the MER must be kept for review and verification as requested. The Contractor will complete and sign the Indian Nation Medicaid Eligibility Rate (MER) Worksheet and Certification Form (**Exhibit D**) for the quarter, and submit this form to HRSA with all claims for the quarter."		
1. The Tribe has signed and completed the MER Worksheet and Certification Form. (Obtain copy of form).		
2. The Tribe tracked and documented the Medicaid eligibility rate for all individuals served, and has documentation on-site of the total number of unduplicated Medicaid individuals seen across participating programs.		
Comments:		

*Any Obligation not met automatically becomes an action item.

Action Items:

IV. Billing

Obligation	Met	Not Met*
Contract reference: **(See Exhibit B, III. Billing and Payment Procedures; G. MAM Reimbursement, and H. MAM Claiming Documentation).**		
1. *The tribe submits timely quarterly billing (A-19's) to HRSA including required back-up documentation (Obtain copies of Billing worksheet, A-19, MER Certification Form, Indirect Rate Cost Form for monitoring file).*		
Comments:		
2. *Supporting documentation of salaries, wages, and travel related expenses is available for review upon request (Obtain copies of salary information; and selected Quarterly Travel Logs if applicable).*		
Comments:		
3. *The Tribe has documentation that salaries are allowable for the purposes of obtaining federal matching funds.*		
Comments:		
4. *The submitted billings are error free. The person signing the A-19/Tribal MAM Coordinator reviews submitted claims for accuracy, and can explain how claims are calculated.*		
Comments:		

*Any Obligation not met automatically becomes an action item.
Action Items:

V. Audit Readiness

Obligation	Met	Not Met*
Contract reference: **(See Exhibit B., III. Billing and Payment Procedures, G and H).**		
1. *Supporting documentation of salaries, wages, and travel related expenses is available for review upon request.*		
Comments:		
2. *The Tribe has documentation that salaries are allowable for the purposes of obtaining federal matching funds. (Obtain a copy of such documentation).*		
Comments:		

Contract reference: **(See Exhibit B. II. Activity Coding, A. Code 7b and 9b).**		
3. *For any staff reporting the use of Code 7b or Code 9b, position descriptions include such activities. (Obtain sample copies of position descriptions)*		
Recommendation:		
4. **The tribe has an audit file.** It is ***recommended*** that the audit file include a copy of the MAM contract, Cost Allocation Plan, training material and training documentation, billing documentation, quarterly travel logs as applicable, staff salary information including documentation of the source of funding, job descriptions of staff using Codes 7b and Code 9b; tribal program descriptions; and organizational charts		
Comments:		

*Any Obligation not met automatically becomes an action item.

Action Items:

VI. Group Discussion – Strengths and Challenges

Additional Information or Activities:

VII. Action Items With Timeframes:

HRSA will:

1.
2.
3.

Tribal MAM Team will:

1.
2.
3.

Appendix K *Tribal MAM Web-site; Resources*

The HRSA Tribal MAM website link contains all of the information and forms referenced in this Cost Allocation Plan, including a list of contracted tribes, the CAP, the Tribal MAM Contract, Billing and Time Study Forms, Monitoring tools, etc…. The website address is:
http://fortress.wa.gov/dshs/maa/mam/tribal/additional_information/Tribal_Links.html

TRIBAL LINKS

Resources:
Washington State Tribal MAM Cost Allocation Plan
List of Contracted Tribes
Washington State Tribal Directory **Updated February, 2007**
Health and Recovery Services Toll Free Numbers
DSHS Web Sites

Tribal Consultation:
December 13, 2005
June 23, 2005

Federal Government Links:
Centers for Medicare & Medicaid Services (CMS) Federal Claiming Guide
Office of Management & Budget (OMB) Circular A-87 (Cost Principles Requirements)
Office of Management & Budget (OMB) Circular A-133 (Audit Requirements)

Training Materials
DSHS Medicaid Eligibility ID Card
Guide To Tribal MAM Activity Coding
Tribal MAM PowerPoint
Tribal MAM Training True/False
Tribal MAM Power Point Quiz Answer Key

Tribal MAM Contract
Contract document

Billing Documents

Washington Tribal MAM Excel Forms (Time Study/Quarterly Travel Log) (Excel)

UPDATED: **Billing Worksheet** (2/26/07) (Excel)

A-19 Example
Medicaid Eligibility Rate Worksheet
Certificate of Indirect Costs

Additional Links:

WAMEDWEB

Medicaid Eligibility

On-line Community Services Application

Department of Printing To order DSHS publications shipped directly to you

Medicaid Eligibility Overview **Updated April, 2006**

Appendix L

AMERICAN INDIAN-ALASKA NATIVE (AI/AN) HEALTH DISPARITIES IN WASHINGTON STATE[1]

The AI/AN population in Washington is diverse, geographically dispersed, and economically disadvantaged. AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington State.

Because disease patterns are associated with adverse consequences of poverty, limited access to health services, and cultural dislocation, AI/ANs in Washington experience disproportionately high mortality and morbidity burden compared to the general population.

- In 2000-2002, AI/ANs had the lowest life expectancy at 74 years.
- The prevalence of type-2 diabetes in Northwest AI/ANs is disproportionately higher than in the general population, with the rate among AI/ANs second only to that for African Americans. Furthermore, the prevalence of diabetes among Pacific Northwest AI/ANs is rapidly increasing – almost doubling between 1996 and 2001.
- Injury-related mortality – notably from drowning, motor vehicle crashes, suicide, and traumatic brain injuries – is highest among AI/ANs.
- Although birth rates for adolescents of all races have declined significantly since 1992, birth rates for AI/AN adolescents were higher than national rates. In general, AI/AN women of all ages were least likely to enter prenatal care in their first trimester of pregnancy.

Furthermore, because obesity, tobacco use, lower socioeconomic status *(as measured by poverty and low educational levels)*, and alcohol and substance abuse are contributing factors for many health problems, the prospects for improving the health status of AI/ANs in Washington will continue to present a major challenge to federal, state, and tribal policymakers unless underlying problems are addressed:

- Almost half of respondents to a population-based survey of AI/AN adults conducted in 2001-2002 were classified as obese, and only a little over one-third of all respondents reported exercising at recommended levels and frequencies.
- Almost two of every five adult respondents to this survey reported that they regularly smoked cigarettes.
- In 2000, AI/ANs generally lived in lower socioeconomic settings than any other racial group – more than 25 percent of AI/ANs lived in high-poverty areas and fewer than 10 percent of AI/ANs lived in census tracts with the highest levels of education.

Perhaps more alarming is the fact that there is abundant evidence that these figures may actually ***underestimate*** the true burden of disease and death among AI/ANs because, nationally and in Washington State, people who classify themselves as AI/ANs are often misclassified as White on death certificates.

There are many other institutional and physical factors that adversely affect individuals' and communities' health status. These include:

- Access to health care – many AI/ANs who use the Indian health system have access only to limited primary care services.
- Lack of health insurance – the proportion of AI/ANs in 2002 who were insured was only 79 percent, the lowest insured rate among racial and ethnic communities.
- Inadequate and diminishing financial support for Indian health programs – over the past 30 years, there has been a chronic pattern of under funding to support these programs.

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[1] The American Indian Health Commission for Washington State and Washington State Department of Health, Progress, Opportunities & Challenges: The 2005-2007 American Indian Health Care Delivery Plan, July 2005.

- Understaffing of Indian health care programs – there are too few AI/ANs in health care careers, and Indian health care programs have difficulties in recruiting and retaining professional staff.
- Lack of transportation – access to health care services often requires overcoming travel challenges, but most reservations do not have transit systems and geographic characteristics often make transportation difficult.

Nonetheless, significant progress has been made in AI/AN health status over the past 20 years on some important issues:

- HIV/AIDS incidence rates have declined among Washington AI/ANs, from over 20 per 100,000 population in 1994-96 to just over 10 per 100,000 in 2000-02.
- Perinatal mortality rates have declined dramatically among AI/ANs in the Pacific Northwest:
  - Infant mortality rate for AI/ANs in the Pacific Northwest declined from 20 per 1,000 live births per year in 1985-88 to 7.7 per 1,000 in 1993-96, but rose slightly to 10.5 per 1,000 in 2001.
  - Almost half (48 percent) of the overall decline in infant mortality among AI/ANs was attributable to the decline in Sudden Infant Death Syndrome (SIDS), with the mortality rate from SIDS decreasing from 8.9 to 3.0 per 1,000 over the same period.
- Many AI/AN adults in the Pacific Northwest are being screened for diabetes and its complications:
  - About three out of every five adult AI/ANs in Washington have been screened for diabetes within the past five years.
  - Although only one-third of active diabetic patients had good glycemic control, over half received clinical evaluation in the past year for:
    - glycosolated hemoglobin – 79.8 percent
    - blood pressure – 82.8 percent
    - serum lipids – 58.7 percent
    - influenza vaccination – 53.9 percent
    - pneumococcal vaccination (ever) – 69.3 percent

A combination of personal lifestyle choices, living conditions, limited access to health care services, and diminished funding at all levels contribute to the disproportionately poorer health status of AI/ANs – but the prevalence of many, if not all, of these factors can be diminished or even eliminated. As noted above, significant progress has been made in AI/AN health status in several key areas over the past 20 years. In order to ensure that the remaining health disparities among AI/ANs are eliminated, Washington State and the tribes must first renew their commitment to implementing effective public health programs as well as disease prevention and treatment strategies
Second, the state should assist tribes in assuring that adequate levels of resources, both financial and professional, are available. Finally, the ongoing government-to-government relationship should continue to raise the issue of improving the health status of AI/ANs as a mutual priority.